University of Alberta

With Woman: The Nature of the Midwifery Relation

by

Susan Gail James ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requirements for the degree of Doctor of Philosophy

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Susan James

901-8510-111 Street
Edmonton, AB T6G 1H7

April 17, 1997

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *With Woman: The Nature of the Midwifery Relation* submitted by Susan James in partial fulfilment of the requirements for the degree of Doctor of Philosophy.

Vangie Bergum
Dr. Vangie Bergum

Patricia Valentine
Dr. Patricia Valentine

Dr. Max van Manen

Phyllis Giovannetti
Dr. Phyllis Giovannetti

C. Benoit
Dr. Cecilia Benoit

April 14, 1997.

The Midwife

A midwife helps us give birth to the new life that is within us.
Wondering together, asking questions like what is hope, love and life...
The seeds of the answers are already within us.

Donilo Dolci. *The world is one creature.*

With Woman: The Nature of the Midwifery Relation

Abstract

The word midwife, meaning *"with woman"* conveys the relational sense of the work of midwifery. Midwives are *with woman* through the physical and emotional care they provide throughout a woman's pregnancy, birth and early mothering experiences and on a more philosophical level, strongly believing in women's capability to grow, birth and nourish a child and to make decisions about her experiences. The women too, are *with woman*; most Canadian midwives are women.

The research question, *what is it like to be with woman?* reflects a desire to develop an in-depth understanding of the experience of being *with woman* as a midwife and as a woman receiving midwifery care. Hermeneutic phenomenology was selected as the research method best suited to the purpose of the study. Data were collected through conversational interviews with women and midwives, observations of situations such as prenatal visits, prenatal classes, births, and homevisits, and aesthetic forms such as art, literature, and movies. Data were analyzed through writing and re-writing.

The analysis revealed five themes. A theme is a particular way of viewing the whole of the experience. The first theme, *setting the tone for the relationship* contributes understanding to the overall approach the midwife and woman take in initiating and developing their relationship. The second theme, *trust* reveals the primacy of trust within the midwifery relation. The third theme, *having a birth experience* explores how the midwife and woman experience birth together. The

fourth theme, *friends, sisters, mothers, and angels* discusses the ways in which the relation is experienced by women and midwives. The fifth theme, *awakening to our women-selves* reveals the nature of women's work as experienced in the midwifery relation.

While the purpose of phenomenology is not to generate theories, the knowledge attained may be useful to midwives and to other healthcare professionals. Midwifery in Alberta is undergoing a period of intense transition as midwives enter the healthcare system as regulated professionals. The final chapter includes a brief analysis of the potential influences, both positive and negative, that regulation may have on the midwifery relation.

Acknowledgement

Behind every student is a wonderful company of supporters who help to smooth the way for this process to occur. I would first like to acknowledge the financial support that I received from the University of Alberta, without which I could not have completed this work. My family and friends in Ontario and Alberta gave unconditional support and love to sustain me, even when I neglected to write or phone. I especially wish to thank my sister Carole and her two babies Scott and Heather for giving me two very special experiences of being *with woman*.

This research could not have occurred without the support of the midwifery community - both the midwives and the women who I have encountered through midwifery work. I was first introduced to the idea of becoming a midwife through my contacts with midwives in Toronto. I then became a midwife because midwives in Edmonton believed that I was serious in my interest in this profession. I especially thank Sandy Pullin for phoning me every second Sunday for two years asking me to return to Alberta and midwifery, and for being an understanding midwife partner. Marie Tutt, Vicki van Wagner, Mary Ann Leslie and Elizabeth Allemang have also challenged my thinking throughout this research process. I am particularly indebted to the midwives and women who agreed to participate in this study.

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Chapter One

What Does it Really Mean to be With Woman?

The work of midwifery is as old as human history. Most languages describe with words various meanings: wise woman, earth mother, old woman. In English, the word midwife means "with woman" (Ayto, 1990). *Mid* is from the old German preposition "with" and *wif* is from the old English word for woman. This is a study about the experience of being *with woman*, as a midwife, and as a woman receiving midwifery care. In this first chapter, I discuss the research question, and how the question lives in my life, my first steps into understanding the question, my choice of hermeneutic phenomenology as the research method to explore this question, and the procedures that I followed to carry out the research. In the second chapter, *Fuelling the Midwifery Fire*, I introduce the context of the study through a description of midwifery in Alberta at the time of the research. Interspersed in this description are historical events, labelled as *flashbacks*, that parallel aspects of the current midwifery situation. The next five chapters are the theme chapters where I explore the experience of being with woman from the perspective of setting the tone of the relationship, trust, the birth experience, friendship and awakening to our women-selves. The final chapter is a summary of how the knowledge gained through this study may influence practice.

The Question

The question, *what is it like to be with woman*? reflects a desire to come to an in-depth understanding of the relationship which occurs in midwifery practice. Hans-Georg Gadamer (1992) advises the researcher that the question not only reflects the existence of an issue, uncertainty, or difficulty, but, the question also invites dialogue, searching, and replies. Vangie Bergum (1991) suggests that the questions that call us to come to an understanding are those that we find in our everyday life. Our questions are not about abstract concepts with which we

have no connection. Our early sense of questioning may come to us as we first enter into an experience and begin to reflect on our understanding of this experience. Our questions lead us to seek understanding of this experience not only for ourselves, but for others who also find these experiences in their everyday lives.

My interest in this question has been evolving throughout my life as a nurse and a midwife. As a nursing student, I was fearful of the power of the relation between the caregiver and the person receiving care. I wondered how I would be accepted, about doing right and wrong, and about finding an "appropriate" level of involvement. When I began my student rotation in obstetrical care, I was assigned to a "special mother" to follow her through the last few weeks of her pregnancy, her birth, and then afterward. I was constantly amazed at her trust in me, her desire to keep in touch, her phone call when she became pregnant the second time, asking if I could be with her again.

In my work as a nurse in labour and delivery, I began questioning why encounters with some women were such a delight, yet with others, such work. I began to be asked by friends to be "their" nurse during birth and wondered again about what made those experiences so different from the ones where the women were strangers. What was the experience like for the woman in labour if her nurse is an acquaintance or friend rather than a stranger? Later, community midwives began bringing women to the hospital where I worked as a nurse, either to act as labour support in a planned hospital birth or when a planned homebirth was unsuccessful. I felt left out of those encounters. What was happening between the midwife and the woman that was so strong that the nurse became extraneous?

As I developed an interest in research, I found that my research questions kept leading me back to questions about relationships. I wondered about clinical issues such as pain management and decision making. But I realized that I wasn't really interested in how much demerol would relieve pain, rather, I wondered why it is that some providers turned quickly to narcotics and epidurals

for a woman's labour pain and others seldom used these interventions. Surely there was something that was happening between the woman and professional provider that contributed to these different ways of practising. I wanted to understand what this might be.

Now I have a midwifery practice and have experienced the relation between midwife and woman. It is never experienced quite in the same way with each woman. Sometimes it is a comfortable trust and other times a very powerful and intense experience. What is this experience like for other midwives and for the women they serve? I have also been in situations where the relation did not seem to be present. The interactional qualities were visible, yet there was an emptiness. What was different about these experiences? In two situations where I felt this emptiness, the primary midwife claimed that it was important for the woman to "do it on her own" so that she would not become dependent upon the midwife. In both these situations, the women had very long labours and were eventually transferred to hospital, however, neither required any medical interventions. What did these women experience? Did they want to "do it on their own?" This concern about dependence of women on midwives is raised by others as well. I have been challenged by non-practising midwives who question the value of continuity of care, of nurturing the relation between woman and midwife. Is "doing it on her own" something that precludes being in a close relation to a midwife? Recently, another midwife asked me if I thought she should take on a new client who had only ten weeks left in her pregnancy. She wondered if ten weeks would be enough time for the relation to develop? Is time a critical aspect to the relation? Does the length of pregnancy enhances or facilitate relations? How is time experienced within the midwifery relation? How do various notions of time influence the relation?

Midwifery in Canada is entering a period of transition. Midwifery is being drawn into the health care system in provinces such as Alberta, Ontario and British Columbia through the professional regulation process. As a participant in this process in both Alberta and Ontario, I have been challenged with the

difficulty in articulating this being *with woman* that we see as being so important to midwifery. This relation is not well captured in the writing of standards and competencies. Its absence makes midwives and the women who have experienced midwifery care concerned that this important relational nature will be lost. We listen to the legislators who state that the only obligation in regulation is to ensure safe practice. Subjective matters between two people and the nature of the relation are not the business of regulation.

From my own experiences, I recognize that the question is not a simple one. The midwifery relation can be seen in the interactions which occur between the midwife and the woman, as well as others with whom the woman is connected in an important way for her childbearing experience. The midwife is also with woman on a more conceptual level, valuing, revering, and seeking the experiences and wisdom of women: Her ancestors, the women healers of the past; her peers, the other women who dare to heal in this medically dominated world; and her partners, the women who come to her for knowledge, expertise, and support for their experiences of pregnancy and birth. A woman may seek a midwife in order to have another woman care for her during this important event in her life. How is this coming together of women during pregnancy, birth and early parenting experienced by the midwife and the woman?

First Steps to Understanding

As the question - *what is it like to be with woman?* - took hold, I began a preliminary search for understanding. Further exploration of etymologic sources suggested alternative meanings for the word midwife such as "a woman by whose means the delivery is effected" (Kramarae & Treichler, 1992, p. 272). Yet the preposition *mid* or with infers a relational sense to the meaning of the word midwifery. With can mean taking care of, accompanying, sharing, influence, possession, understanding, or against (Oxford Online Dictionary). Connecting the word midwife to the sense of the relational nature of midwifery care led me to seek further understanding of what it really means to be with woman. I reviewed existing research related to the midwifery relation as well as other sources of

knowledge such as historical descriptions of midwifery, philosophical discussions, anecdotal descriptions, and aesthetic forms. Historically, women's knowledge has often been left out of scientific discourse (Sharp, 1986). Therefore, it is essential that other sources are studied in order to capture women's knowledge and experience (Belenky, Clinchy, Goldberger, & Tarule, 1986; Reinharz, 1992). A review of these sources helped to clarify and introduce depth to the question.

Relation - Coming to an Understanding of the Concept

The research literature in health care tends to reflect a reduction of *relation* to interactional tasks, for example, a time and motion study of caregiving in labour and delivery (McNiven, Hodnett, & O'Brien-Pallas, 1992), an ethology of comforting interactions (Bottorff & Morse, 1994), and an analysis of communication content during labour (Bergstrom, Roberts, Skillman, & Seidel, 1992). Are these interactional tasks the foundations which form a relation between woman and midwife? Is it possible that these tasks may be performed in the absence of a relation?

A relation is an interaction that has an intentional nature (van Manen, 1991). To be *in relation* involves more than coincidental presence in the same place or space as another person. Some form of interaction, not necessarily verbal, is required to make the meeting of two into a relation. The intentions or the motives of a relation vary, from the pleasure of the company of another in a friendship-type relation to the particular services or skills brought to a professional-type relation. There are many forms of relation ranging from one extreme of intimacy and support to another extreme of distance and adversary.

Max van Manen (1991) describes the pedagogical relation between teacher and child as having a reciprocal nature, with both the teacher and child benefitting from the relation. To be in a pedagogical relation with a child, the teacher must embody the content which is taught, must be concerned not only with the end point of accomplishing the curriculum, but also with the child as she or he is and as she or he may become. The child is not passive in this notion of relation; the child must also have a willingness, an intent to learn. Is the

midwifery relation pedagogical? There are certainly similarities in that both occur within a concrete time parameter with a potential for long-term memories or attachments. However, the midwifery relation generally occurs between two adult women and has the potential to be renewed several times throughout a particular woman's childbearing years. Within the context of Canadian midwifery care, a woman makes deliberate choices as to who her midwife will be.

Thomas Moore (1994) describes a relation as "grace", a way of being with another that is "soulful." In his view, relation is not only about the persons actually involved in the relation, it is also a connection beyond, with humanness, with infinity or destiny. Sally Gadow (1993) describes the relation between the caregiver and the person receiving care as "the mutuality of both persons speaking their own grounding, their particularity, as the means of reaching toward the other" (p.11). She believes that it is only in the context of relation that adequate meaning for the basis of moral action can be discovered. Julia Kristeva (1986) also encourages a focus on relations as a strong source of moral knowledge and action. She argues that social relations are an inherent aspect of each individual's humanness; that no external "laws" ought to be required for assuring relations. She views the individual person as a "subject-in-process" who forms relations through a love of the differences between self and another "subject-in-process" rather than through a search for sameness. Does the midwifery relation have moral consequences? Is it through relation that we are called to another (Levinas, 1985) perhaps even more strongly than through professional standards or codes of conduct?

Perhaps the midwifery relation is a form of friendship. Susan Poslusny (1991) suggests that a metaphor of friendship ought to be developed to describe the incorporation of subjective knowledge gained through interaction with a scientific perspective in professional health care relationships. Like the relational ethic of Sally Gadow and Julia Kristeva, she encourages an ethic of friendship that is based on the values of care, accountability and truth.

> Friendship is an experience shared by individuals that creates a climate of discovery, encourages learning about oneself and others, and creates shared meaning about the world and reality. Friendship involves discovery, learning, and sharing; or meeting, engagement and connecting (p.167).

Others such as Lorraine Code (1991) encourage a friendship model in professional relations because of the centrality of trust within friendship. Within this view, knowing and trust are seen to be synergistically related, where knowing leads to trust and trust results in deeper knowing. Do we perhaps confuse friendship with a friendly approach? Is friendship an essential component to the midwifery relation? Can the relation occur without friendship? Can trust occur outside of a friendship relation? Since the midwifery relation is often time-limited, is this the same type of friendship as that which occurs between people outside of caregiving situations? Does the use of friendship in this context somehow belittle the notion of friendship? Perhaps friendship is too much and at the same time too little to describe the midwifery relation.

The Midwifery Relation - Mutual Embodiment

Jacques Sarano (1966) suggests that it is through embodiment, the engagement of self and body, that people are able to recognize their own humanity and form relations with others. This is congruent with the work of Maurice Merleau-Ponty (1962) and of Iris Marion Young (1990) who have conducted phenomenological studies of the embodied experience. Both suggest that it is through the experience of living within a body that a person is able to connect with the rest of the world. Iris Marion Young (1990) suggests that the embodied experience for women is different than it is for men. Therefore, it is important to study women's embodied experiences, rather than to merely apply knowledge gained through men's experiences.

Virginia Beane Rutter (1994) describes the psychotherapeutic relationship between a woman patient and a woman therapist as having strong bodily associations, where two "alike bodies" share knowledge. "One-to-one

relationships between women call up uterine existence - deep, intense primordial feelings." (p. xv) She views major events in women's lives such as pregnancy and birth as arising in the body and simultaneously affecting the mind and the soul.

Embodiment has particular significance for the midwifery relation. Much of the attention of caregiving during this period is focused on the woman's body - the growing child within, her external body changes, her perceptions of her body, the intimate touch of birthing and nursing the child. For many women, birth is a sexual experience (Kitzinger, 1983). The comfort of both the woman and the midwife must reach a level that permits the intimacies of one body touching another. Monique's story expresses some of the aspects of embodiment within the midwifery relation.

Monique's Story - Searching for Trust

Monique came to a midwife for her second birth. Her first birth was a cesarean section. She remembers the experience as being extremely abusive. For this birth, she sought a different experience, one where she could have trust in her caregivers to keep her in a safe and comfortable place, not to abuse her.

> *When I was labouring at home, I was just so sure that I was safe. I trusted that the midwives would keep me safe. I trusted them, I trusted myself. I just knew that my body could do it, I was not afraid. My body was whole and healthy and capable. I was strong. Even the pain of labour and pushing did not make me afraid. I felt even stronger as the night went by.*
>
> *I ended up having to be transferred to the hospital after a long time of pushing and the baby wouldn't come. The midwives came with me. So, even though I was in the hospital, this was still my birth, with the people I wanted. They acted as a buffer between the hospital staff and me. When I didn't feel like speaking up, they made sure that decisions and the things the doctor and nurses wanted to do were ok with me. I really didn't want to go to sleep for the cesarean and they kept reminding everyone that this was my biggest wish. Denis felt so much better this time. With our first baby, he felt completely out of control.*
>
> *During my pregnancy, I wondered how birth might be different with a midwife. I was sexually abused as a child. To me, my first birth was another abusive experience. Almost all of my experiences with doctors*

have made me really really uncomfortable. The obstetrician I went to would just put on a glove and stick his hand up my vagina - he never even looked at my eyes - he never really talked to me. Doctors just poke and prod my body. I guess they knew parts of my body, but they never knew me. The midwives never seemed to want to poke and prod. How would the midwives treat my body when they didn't know it from my visits with them? What would it feel like to have the midwife doing a vaginal examination during labour when the midwife did not know my vagina? What it would feel like to be naked when the midwife had never seen me naked? But, I realized that the midwife knew me and accepted me. With the midwife I could be a whole person. My body is part of me - it didn't matter what the midwife saw or did. It was not like I lost my dignity when I was in labour. I gained dignity in their respect.

How is the relation between woman and midwife an embodied relation for the midwife? Virginia Beane Rutter (1994) identified the embodied connections between two women who work together in psychotherapy. How is this experienced by the midwife? Robbie Davis-Floyd and Elizabeth Davis (in press) recount stories told by midwives of knowing or intuiting through their bodies. For example:

> In our collective practice, one of the things that we became really aware of over time was that if one of the midwives at a birth had diarrhea [it was a message that we should] look at things a lot closer. Inevitably in those births something came up... I think you're intuitively picking up that something isn't quite right here. It's coming out in the body... it hasn't gone into the head yet (p.8).

What role does relation have in this embodied knowing? Does an openness to connection with the woman create paths for knowledge that might not otherwise be present? Are there other embodied experiences of the midwife that come about through the midwifery relation? At a session led by Elizabeth Davis at the MANA (Midwives' Alliance of North America) conference in Chicago in September 1994, midwives told stories of having milk let-down or beginning to bleed (when their periods were not due) when providing care for women with whom they felt particularly connected, especially when in difficult situations.

The Midwifery Relation - Situating the Experience

In the midwifery relation, the midwife directs or focuses her attention, her knowledge, her skills, her humanness toward the woman in order to support the woman in this pregnancy and birthing experience. Yet, this is not a unidirectional relationship. Midwives claim to learn about themselves, about their bodies, about women, and about life itself through their relations with women.

There are many aspects about the experience of pregnancy and birth which create opportunities for relations to form. Vangie Bergum (1989), Robbie Davis-Floyd (1992), Kathryn Allen Rabuzzi (1994), and Virginia Beane Rutter (1994) all note pregnancy and birth as being a period of transformation, a time of seeking connections. The nature of midwifery - such as continuity of care, making time, watchful waiting, choices, homebirth, women centred, and family focused - provides fertile ground for relations to germinate, to grow, to bloom, and to propagate. Diane did not know the midwives for a long period of time during her pregnancy. Yet, her story also reveals the midwifery relation.

Diane's Story - Love is Really Important

Diane decided on a homebirth after being given lots of confusing information from her doctor - for example, even though she was sure she was due in late December, he wanted to do a cesarean in November because she was too big and he was sure her baby was in the breech position.

> *I'm not very proud of my body and so I tend to keep it covered up as much as possible at all times. I won't wear shorts ever. But there was such a feeling of support and acceptance from the midwives that by the time I gave birth, actually, half way through, I was completely nude and it didn't bother me in the least. There was no judgement from them, it was very much acceptance. And also acceptance of whatever I chose to try to alleviate my discomfort. It was just overwhelming, waves of `you're doing fine' and `your decisions are right' and `we will support you.' And it was wonderful. Very warm feelings from all the midwives.*
>
> *I felt like I was surrounded by friends, even though I hardly knew any of the midwives. I had only met Christine once, for example. But, it was because of the way the midwives acted and reacted to things that were going on. When I'd say I couldn't go on any more, there was immediately a hand touching part of me massaging, or cold ginger ale*

right there, or a cool cloth on my forehead, and just the quiet `you're doing fine' and `things are good' and `your baby will soon be here.' It was just wonderful. It was like being surrounded by a circle of my very closest friends who were just there to help me through.

For a woman to have a homebirth, she has to have confidence in herself that she is going to make the right decision and not allow everybody else's negativity to try to shake them. And she has to have confidence in her caregivers who are going to be there for her. The midwives were absolutely there and not just physically, but almost mentally as well. I could feel the support and the caring. The other thing is that love is really important - it's one of my most major important things ever. It seems a funny word to use with women I hardly know. There was such an atmosphere of love in that room, particularly when he was born.

During this time in a woman's life, there is much opportunity for disempowerment, fear, and concern. The vulnerability of pain, of fear, of exposure can bring even the most confident woman to an experience of dependence upon the "wisdom" of others. The advance of technology and medicalization of birth makes us forgetful of the woman's experience of her pregnancy and birth. There is evidence that midwives and physicians have very different perceptions of pregnancy and birth. Midwives tend to view pregnancy as a natural state or normal process, whereas physicians view this as a risk state (Schuman & Marteau, 1993). In *The Essence of Midwifery* (Walsh, 1993), the differences in the perceptions of the midwife and of the physician are described.

The Essence of Midwifery

Linda V. Walsh

He who uttered the words "Routine Delivery"
Or hastily wrote "Normal Spontaneous Delivery" as
one further procedure in a busy day
Couldn't have really been with her.
He couldn't have been
Or he would have felt her muscles as they
worked
strained
pushed
that infant into the world.
He couldn't have been

Or he would have truly felt her perspiration weep from
her body as she reached for strength deep
within.
No, he couldn't have really been with her.
If he were, he would have appreciated her expression
as it changed from excitement, to concentration,
to fear, and to excitement and peace.
He couldn't have held her,
Whispering
"You're almost there"
"You're doing so beautifully"
"You're so strong."
Routine delivery.
He couldn't have been there.
He couldn't have taken the time
to pause in awe and wonder
as that little head came slowly, ever so slowly,
and the eyes opened and looked out with such trust
and wisdom.
Procedure-normal spontaneous delivery.
He couldn't have been with her.
He couldn't have marvelled as she reached down,
drawing her daughter to her breast.
Laughing, shouting, crying - all the emotions of birth.
No, he couldn't have been with her.
For she who has been with woman knows there is no
routine birth, and that delivery is not a
procedure.
Being with woman is opening up,
sharing,
loving,
caring.
Being with woman is truly being a midwife.

At the present time, there is also opportunity for disempowerment for the midwife. Her status within the health care system, the traditions of medical domination, and new regulations that may move midwives into a medical model of practice may threaten the midwife's ability to fully engage in relations with women.

Through feminist ethnography, Margaret Reid (1989) studied the experience of professionalization of midwives in the United States. As one area

of her findings, she identified aspects of the midwifery relation, both as it existed early in contemporary "lay" midwifery, and as it has evolved through the experience of professionalization. Although the relational aspect of midwifery care was the feature of midwifery least affected by professionalization, she noted some changes in the nature of relationships between midwives and women. In the 1960's and 1970's, when women first began seeking assistance outside the mainstream healthcare system, relations were mutual, trusting, and sharing. The responsibility for the birth lay primarily with the woman giving birth and the midwife was the helper, the friend. Later, as midwives became drawn into "professional" work, the relation became more formal and tended to be focused on the pregnancy and birth, particularly as they are defined within the medical model. Rose Weitz and Deborah Sullivan (1985) also found that midwives adopted the medical model as they became professionalised.

Margaret Reid (1989) found that many women abdicated their central role in being responsible for the pregnancy and birth, perhaps believing that paying a fee to the midwife implied buying responsibility. Despite these changes, women did report relationships with midwives that were more open and less formal than with other health care professionals. However, the author is cautious in her conclusions, questioning whether midwives can both work in the domestic sphere and gain professional respectability. Midwives in Canada are at various stages of the professionalization process. It may be expected that the range of experiences of the midwifery relation in Canada will reflect Margaret Reid's findings.

Hally McCrea (1991; 1993) conducted a qualitative study of factors which affect the midwife-client relationship. In this study, sixteen midwives in the United Kingdom were asked to describe the women they were likely to meet in their practice and to give examples of good and poor relationships that they had

experienced with women. Dilemma analysis[1] was performed on the interview data to reveal two major factors which influenced the midwifery relation. These were identified as the nature and value of the midwife's role (as perceived by the midwife) and the recognition of the authority and autonomy of the midwife (by others, as perceived by the midwife). Midwives who reported feeling little self-worth through not feeling needed by women, or not feeling respected by women or other professionals also reported that they felt inhibited in forming relationships with clients. This was identified as an action research method and in keeping with this, the findings were "translated" into recommendations for organizational changes such as increasing the number of midwife-managed maternity units, encouraging continuity of care, and the development of assertiveness skills on the part of midwives.

Although this study provides some useful insight into how midwives in the United Kingdom view the midwifery relation, its overall value in explaining the midwifery relation as experienced by midwives and women in Canada is minimal. Midwives in this study did not practice continuity of care nor under their own authority. Women did not choose a particular midwife, rather they were assigned to an available midwife for prenatal appointments and when they came into the hospital for labour and birth.

Most midwives in Canada have a history of working alegally within the context of a medically dominated health care model. Within this medical model, relations between professionals and the people receiving their care tend to be authoritative (Davis-Floyd & Davis, in press), relying on the application of general principles and theories to the particulars of the individual situation. The Canadian Medical Association (Sullivan, 1987) conducted a survey of women asking what kind of care they had received for their births, and whether or not they were satisfied with this care. From the data collected, they concluded that

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[1]Dilemma analysis involves examination of the interview data for issues which created conflict, stimuli which raised those issues and how the issue was or was not resolved. In McCrea's (1993) study, the researcher's findings were verified by the participants in the study.

the legislation of midwifery was not justified in Canada because very few women used midwives and because the women reported satisfaction with the care that they received from physicians. No questions on the survey measured relational issues. Although the findings of this study contribute little to an understanding of the midwifery relation, the absence of questions about relations in the survey reflects a lack of value or understanding of non-authoritarian relations within the existing health care system. This study is also reflective of the difficulties that women and midwives may have in gaining legitimate acceptance of their experiences within the midwifery relation.

Within the context of the technocratic health care system, only those phenomena that can be consistently measured in an objective way and can be used to describe, predict and control are considered to be valid forms of knowledge. The "subjective" or "experiential" nature of phenomena such as relations between caregivers and the people receiving their care results in a dismissal of the relevance of such phenomena in health care research, or an oversimplification of the phenomena so that they can be measured. In the Canadian Medical Association study (Sullivan, 1987), satisfaction with care was measured using a visual analogue-type scale asking respondents to rate their satisfaction with the care they received. Other researchers (e.g., Williams, 1994) have begun to question the validity of satisfaction as an outcome measure. Perhaps such overwhelming satisfaction would not have been found if more components of the experience were examined. For example, it has been found that when women experience differences in interests and inequalities in power within their relationship with a physician, they are generally unable to obtain the information that they want (Shapiro, Najman, Chang, Keeping, Morrison, & Western, 1983). If the measurement of "satisfaction" was composed of many factors including the type of relations expected and experienced, the Canadian Medical Association may not have found that women report such high satisfaction with the maternity services that currently exist in Canada.

Historically, there is little direct information about the midwifery relation as it was experienced by Canadian women and their midwives prior to the evolution of the "new birth culture" in the 1970's (Barrington, 1985). There was not a system of organized prenatal care and often the midwife was called out only on an emergency basis (Sharp, 1986). However, the midwife in the community was generally well known to the women of the community. She shared other community activities with women, she was one of them, not the professional from another world. Her knowledge was special, yet from within the same world as the woman's knowledge. Through studying the practices of midwives in the Ozarks, Appalachia and the South, Sharon Sharp (1986) suggested that our knowledge of the actual practices of midwives in the past has been limited through the tendency to write history from men's experiences only. Because the work of women healers, including midwives, was an expected part of the role of women, it was not considered to be remarkable, nor worth noting in historical accounts. There is evidence that women experiencing midwifery care at home in Canada at the beginning of this century had better morbidity and mortality outcomes than women who experienced care from physicians and nurses at home and in hospital (Mason, 1988). Perhaps some of the women's knowledge that has been "lost" or perhaps only "misplaced" was related to the beneficial qualities of particular kinds of relations in providing midwifery care.

The Midwifery Relation - More Than "Getting to Know You"

Midwives claim to highly value the relation between women and themselves. Most practising midwives prefer to work in a primary care model or very small group practice, schedule long appointments, and do home visits so that the midwife and the woman "get to know" one another very well. Is this "getting to know" merely an uncovering of facts between two people? Is there a balance in who gets to know whom? How does forming a relation influence "knowing"? Patricia Munhall (1993) describes *intersubjectivity* - "the verbal and nonverbal interplay between the organized subjective world of one person and the organized subjective world of another" (p. 126) - as a way for mutual

knowledge to evolve between a caregiver and a patient. Through intersubjectivity, an openness occurs which allows both woman and midwife to be "knowers," for the midwife to come to an understanding of the meaning of the experience for the woman. What is the value of this knowledge for the woman? For the midwife? If intersubjectivity is about mutual knowing, does the woman come to understand the meaning of the experience for the midwife? Does she need to?

In a book on homebirth, Sheila Kitzinger (1991) describes the role of the midwife to women contemplating homebirth as a professional who relates to the woman with mutual respect, warmth and openness.

> A good midwife loves women. She does not dominate, direct, or even instruct. Except on the rare occasion when she needs to take decisive action to avert danger, she follows rather than leads. She is the midwife to all the dreams and hopes surrounding the coming to being of that child, and to the process of maturing and growth that is involved for both parents (p.76).

Through a hermeneutic phenomenological study of women's experiences of homebirth (James, 1993), I found that women having homebirth talk about developing a special relationship with their midwife, one that is very different from any previous professional caregiver relationship. Women feel that their midwife has come to know them through many hours of contact prior to the birth, some at the midwife's office, some in her own home. Confidence in the midwife's abilities is extremely important, yet the relationship between the woman and her midwife is based on more than professional competence. Women gain a sense of respect, confidence, love, and empowerment from their midwives. The midwife creates a woman centred experience. She knows the woman and understands her vision of her birth. The woman knows that her midwife will be with her for the duration, no matter what.

Vangie Bergum (1989) conducted a hermeneutic phenomenological study of women's experiences of becoming a mother. One of the women in her study had a homebirth with a midwife. From that woman's experience, Vangie Bergum

identified the relationship between the midwife and woman as one of mutual respect and trust. The relationship is based on a commitment to spend time with the woman, getting to know her as a person, and on specialized midwifery knowledge of the nature of pregnancy and birth.

In a feminist human geography study of why women choose homebirth, Sally Abel and Robin Kearns (1991) found that the ability to exert control over her birth experience and continuity of care were the central issues in the woman's choice. These Australian women described the relationships developed with midwives through the continuity of care as becoming more than simply people getting to know each other. The relationships were also based on common attitudes to birth which differed from those that are accepted within hospitals. Although Australia has had a long established system of midwifery, the findings of this study may be informative for the Canadian experience because midwives who do homebirths in Australia are marginalized in a similar way to midwives currently practising in Canada.

Lesley Page (1993) described the relationship between the woman and the midwife as one of "skilled companionship." It is through the relationship with the woman that the midwife is able to carry out her work in a safe, thoughtful, and embodied way. The midwife is able to bring the woman's personal world together with the world of maternity services. Other outcomes of the midwifery relation that have been suggested include lower incidence of low birth weight infants (Levy, Wilkinson & Marine, 1971), decreased rates of infant mortality (Tew, 1991; 1995), improved maternal and neonatal conditions (Haire, 1981), reduced incidence of cesarean section (Butler, Abrams, Parker, Roberts, Laros, 1993; Sakala, 1993), and reduced incidence of hypertension (Wagner, 1996).

Fiona Hanley (1993) recounted Canadian women's descriptions of their experiences of midwifery care. One woman reported that she developed of a sense of confidence and happiness about her pregnancy and birth through her relationship with her midwife. Another woman described her relationship with her midwife as being equal and one in which she felt comfortable asking questions.

Barbara Katz Rothman (1989) described midwifery as feminist praxis. In her view, the midwife works with the woman in creating or transforming a birth experience which meets the needs of the woman. By being ideologically connected with the woman, the midwife creates unity rather than dualisms such as mind-body and woman-fetus. Others such as Emily Martin (1985) and Robbie Davis-Floyd (1994) also suggest that midwives consider the woman and her (unborn) child as a single entity rather than as two separate "patients."

Perhaps the midwifery relation assists in decision making. In a study of clinical decision making by various care providers including midwives, Laila Orme and Christopher Maggs (1993) concluded that expert decision making can only take place within a philosophy of care. Yet in this study, the philosophy of care is not defined as a relational approach. Rather, the caregiver is put in a powerful position to make decisions which may in fact be in conflict with those of the person receiving care. Midwives are sometimes in situations where fast and directive decisions are required - the baby that needs resuscitating, the woman who is hemorrhaging. How does the relation between the midwife and woman influence these decisions? Does the need to be directive somehow interfere with the relation? Or does that relation make decisions easier, more appropriate?

Perhaps the midwifery relation may be a way of facilitating the woman's participation in her experience of pregnancy, birth, and childrearing. Vivian Littlefield and Barbara Adams (1987) randomly assigned women to a birthing centre with some form of midwifery care or to a conventional labour and delivery unit and measured the women's sense of participation, satisfaction and locus of control. They found that all women had a high locus of control. There were no differences in "satisfaction" between the two groups; however, the birthing centre women reported a higher sense of participation in their births. Because it is unclear how the midwives practised in this study, the data in this study are not sufficient to conclude that the midwifery relation contributed to this difference in the women's sense of participation.

The literature reviewed here has provided some insight into the nature of the midwifery relation. It appears that the relation goes beyond sharing of professional knowledge and expertise, beyond getting to know one another. The relation may contribute to improved outcomes for the woman and her infant, and to giving the woman some sense of her power in the experience of childbearing. The midwife may also gain through participation in the relation. There is a possibility that the midwifery relation may be at risk within the changing healthcare system.

The Method

In determining the most appropriate method for this question, I reflected on the research that had been done to date. In addition to the research reviewed above, other research by and about midwives tends to be focused on scientific measurement of mortality and morbidity outcomes (e.g., Tyson, 1991) or on the history of midwifery (e.g., Mason, 1988). While these forms of research are essential to the ongoing development of knowledge about and for midwifery, the methods employed did not seem to be a good match to this question. I sought a method which would enable me to study the experience of being with woman in an in-depth way, that would accommodate personal reflection, and that would result in a text that would permit others to understand this experience as well.

Hermeneutic Phenomenology

In keeping with the nature of the question and the purposes of my study, the method selected is hermeneutic phenomenology. Max van Manen (1990) describes phenomenology as

> question[ing] the way we experience the world, want[ing] to know the world in which we live as human beings. And since to *know* the world is profoundly to *be* in the world in a certain way, the act of researching - questioning - theorizing is the intentional act of attaching ourselves to the world, to become more fully part of it, or better, to *become* the world (p.5).

The use of this method requires that the researcher becomes committed, passionate, and connected to the question, the discovery, and the uncovering of knowledge and of meaning.

Hermeneutic phenomenology involves both description (phenomenology) and interpretation (hermeneutics) of human experiences within the everyday world of life (van Manen, 1990). The aim of this research method is to come to an understanding of the meaning of a particular lived experience. Hermeneutics requires an attentiveness to language, a sense of the interpretability of life, and an interest in the meaning of human life (Smith, D., 1991). Theories are not considered to be the natural outcome of hermeneutic phenomenology. In fact, there may be no sense of conclusion or summary at the end of a research report, recognizing that the text itself is what conveys the understanding of the experience in question. The research may, however contribute a deeper understanding to its readers who may then bring this enhanced knowledge into their own everyday experiences.

This method is built on a rich tradition of philosophy (Munhall & Oiler, 1986 a,b; Ray, 1994; Smith, M., 1991). The origin of phenomenology is attributed to Husserl who began the study of consciousness. In phenomenology, the project is to develop an in-depth description of a phenomenon of lived experience. Hermeneutics was later associated with phenomenology, with each subsequent philosopher adding his personal signature to the understanding and practice of hermeneutic phenomenology. Dilthey added a historical dimension to interpretation, claiming that history creates a sense of connection in the world (Smith, D., 1991). Heidegger introduced the questioning of the meaning of "Being in the world" as a form of interpretation of experiences (Ray, 1994). Gadamer added the sense of the "horizon" which is the knowledge, experiences, understandings, values, and beliefs of the person. This horizon is important in starting the questioning that leads to the inquiry, and in shaping the interpretation (Smith, D., 1991). Other philosophers such as Merleau-Ponty, Ricoueur, Foucault, Habermas, and Derrida have also contributed to the understanding of

hermeneutic phenomenology. This rich heritage has contributed to a variety of "schools" of phenomenology (Cohen & Omery, 1994).

Hermeneutic phenomenology is often classified as being within a subjectivist world view and associated with a nominalism or constructivism perspective. In keeping with this perspective, a researcher using this method seeks an understanding of questions, not a solution to problems (Burch, 1986). The research method arises from a belief that reality - what we can come to understand about a phenomenon is always more than what can be objectively measured or sensed. While quantitative research methods limit "acceptable" data to objects or phenomena which have a stable nature and can be counted or measured in a physical way, hermeneutic phenomenology accepts, even demands an inclusion of other forms of data including emotions, perceptions, and beliefs (Morrow & Brown, 1994). Text, gestures, speech and artifacts are all acceptable forms of data. These inform the research because as expressions of life, they are connected to experience (Smith, D., 1991). The aim of the research is not to discover the particular meaning of a particular word or action, but to understand a deeper context of what is present, what the experience is that gives rise to those particular words, actions, texts, or artifacts (Smith, M., 1991).

Our understanding of our experiences, of our world is mediated by our consciousness. For each individual, consciousness is a reflection of their lives: experience, education, family, culture, and community (Cody & Mitchell, 1992; van Manen, 1990). Even though we may be able to "see" or even "measure" in some way that an individual is a midwife providing care to women or a woman receiving care from a midwife, we recognize that each individual lives that experience in a way that is particular to that individual. Rather than seeking a common definition of this experience, we welcome the diversity which brings a depth and richness to the possibilities within our understanding of this experience. The researcher also brings their individual consciousness to the research process. Therefore, rather than expecting that each researcher asking the same question would be able to closely replicate the findings of the others,

we accept that it is possible to develop various understandings of a particular experience being researched.

In hermeneutic phenomenology, it is also acknowledged that there is a historical-temporal dimension to our understanding. All that occurs in the past, present and future influences the nature of our understanding at any particular moment (Heidegger, 1977). Rather than limiting our research interests to phenomena that cannot change in any way, that can be measured and re-measured consistently, we recognize that the understanding of experience evolves. While the experience itself of receiving care from a midwife two years ago does not change with passing time, the individual's understanding of that experience may evolve, perhaps developing changing levels of depth, taking on various connections, or varying in significance. Merely asking an individual to participate in research and reflect upon an experience can change the nature of understanding of that experience (van Manen, 1990). In keeping with this perspective, it is recognized that we can only approach full understanding, that full understanding of the complexities of experience is unattainable (Bergum, 1991; Smith, D., 1991). There is no sense of "saturation" - of finding all there is to find in a particular category or aspect of an experience - that is part of some qualitative research methods such as grounded theory. The aim of the researcher is to seek an in-depth understanding, not to develop a generalizable theory or prescription for practice based on a sense that we know all there is to know, that it is unlikely to change, and that all alternative understandings are invalid.

In hermeneutic phenomenology, there is no separation of induction and deduction. Gail Mitchell and William Cody (1993) suggest that "even induction and deduction taken together are inadequate to describe in full the human process of understanding and interpretation" (p. 176). Carolyn Oiler (1986) describes the logics of hermeneutic phenomenology as being an inductive-like process that can be learned. Reflection is also used to describe the process of coming to an understanding of meaning. Reflection is a means of "appropriating,

clarifying and making explicit the structure of the lived experience" (van Manen, 1990, p.77). The researcher maintains contact with the experience during the research process by engaging herself as a person who has had some form of experience related to this phenomenon. The process of engagement is quite different from comparison. Comparison is more closely aligned with an objective perspective where it is possible for the researcher to apply the procedure of the logic while staying at arms length from the experience. With engagement, the researcher is part of the experience (Smith, D., 1991).

Some may question the value of hermeneutic phenomenology, suggesting that this becomes a form of solipsism where only the individual can know and understand the meaning of a particular experience (Morrow & Brown, 1994). Indeed, if this was the claim of hermeneutic phenomenology, we would have to ask how the researcher could possibly understand the experience of those participating in the study and how anyone reading the research could possibly understand the experience as it has been interpreted and reported by the researcher. However, there is a sense that understandings can be shared or known by more than one person. Through the process of living, we not only develop individual understandings, we also develop relational knowledge. Through our relations with others, we let go of our sense of self so that the experiences which occur within that relation result in a shared understanding (Smith, D., 1991). We come to understand the experience of another through a willingness to be open, to learn, not by standing back at an objective distance. Readers of hermeneutic phenomenology may come to an understanding through engaging in reading the text of the research. It is the task of the researcher to create a text that calls to that engagement. While generalizability is not a goal of this research, there is an intent that the researcher and others are able to come to an adequate understanding of the experience so that the research may have an action component (van Manen, 1990).

Critics of hermeneutic phenomenology may suggest that in the absence of replication and objective measurement, this is research of the abstract.

However, the entire purpose of this method is to understand experiences in everyday life (Bergum, 1991). In this study, the midwifery relation was observed, asked about and participated in particular situations where "being with woman" is most likely to be found. A "good" phenomenological description is one that stimulates in the reader a sense of connection to actual or potential experience. It is "collected by lived experience and recollects lived experience - is validated by lived experience and it validates lived experience" (van Manen, 1990, p.27). The task of the researcher is to stay with the experience and not to move into the abstract.

Can a Feminist do This?

This study is about women. As a feminist, I must consider the "goodness of fit" between hermeneutic phenomenology and feminism. Is there such a thing as feminist phenomenology? Feminist research is not any particular method, rather a particular consciousness regarding research. Within this consciousness are a variety of themes including a critical analysis of non-feminist scholarship, a goal of social change, representation of human diversity, inclusion of the researcher as a person, the development of relations between the researcher and the people participating in the research, and the definition of a special relation with the reader of the research (Reinharz, 1992, p. 240). Perhaps a more appropriate question is: how would a feminist do hermeneutic phenomenology?

There have been arguments from both feminists and from phenomenologists that there can be no such thing as "feminist phenomenology" (Flax, 1990; Levesque-Lopman, 1988). The feminist arguments suggest that phenomenology is too tied to the existentialist world view which claims that human actions are voluntary and in no way affected by social and cultural factors such as gender relations, class, and race. Feminist scholars who are uncomfortable with any analysis of data beyond reporting of the "raw data" may find the interpretive or hermeneutic approach of phenomenology too much like an expert voice speaking for others. In some cases, the fact that the traditional

phenomenological philosophers (e.g. Merleau-Ponty) have written about lived experiences from a male perspective, has led to a complete rejection of phenomenology as a method appropriate to feminist enquiry. Other feminist criticisms of the philosophical origins of phenomenology highlight the tendency of some philosophers such as Hegel to support a dualistic perspective of self and other (Whitbeck, 1989). Feminist empiricists have criticized phenomenology, like other qualitative methods as being unsystematic and unscientific (Jayaratne & Stewart, 1991)

The phenomenologist arguments focus on the inappropriateness of approaching research from any stand point or perspective. If one is to learn about the phenomenon of interest through examination of the lived experience of that phenomenon, it is through living that the reality of experiences such as oppression will be known, not through an imposed theory of that experience. The acceptance of the notion of persons-in-process and knowledge-in-process within the phenomenological perspective dissuades the phenomenologist from making final conclusions, recommendations, or generalizations which could then be used for political action (van Manen, 1990).

However, on both sides, there is an incompleteness to the argument that feminist phenomenology is impossible. Much of the epistemological and methodological underpinnings to phenomenology are completely congruent with feminist research objectives. The interest in everyday life experience, listening to the voices of those in that experience, situating the phenomenon of interest, forming strong relations with the research (and ultimately with the people included in the research), validating interpretations of the experience, and putting the final results into a written form that is evocative (van Manen, 1990) are all recurrent themes and directions within feminist methods. Using feminist methods does not always imply using a feminist lens on analysis. For example, in feminist postmodernism, no existing theory would be used as a standard against which research findings are measured. Feminists such as Iris Marion Young (1990) have examined traditional phenomenological philosophy and have developed

equally strong phenomenological texts of women's experiences, for example *Throwing like a Girl* (1990). Feminist aims in research can be accomplished through many aspects of the research process.

One must also question whether being a feminist is different from any of the other personal qualities that a researcher may bring into the research process. Through the reflection required during the analysis stages of the research, the researcher, whether feminist, non-feminist, or anti-feminist must seek to become conscious of their own preconceptions and the biases that these may raise.

A further concern that has been raised is that as a feminist, I may focus on the woman to the exclusion of the other important relations in her life - her partner, her children, her unborn child. The scope of this particular research is the experience of *being with woman* for midwives and for the women receiving midwifery care. While the full experiences of being a midwife or of pregnancy, birth, and early parenting are intriguing, these are beyond the scope of this research. Also beyond the scope of this research are the relations between midwives and unborn or newly born babies and between midwives and partners of women. Questions related to these experiences have been addressed by other researchers (e.g., Bergum, 1989; 1987; Martin, 1985; Rabuzzi, 1984) or remain as challenges for researchers in the future. However, this particular scope that I have selected for this study need not imply an disinterest in these experiences. Feminist research is not anti-male or anti-child (Reinharz, 1992). In order to understand the experience of women, it is important to acknowledge that women do not live in isolation. Each woman is connected to multiple layers of relations: some continuous and deeply intimate, others momentary and seemingly inconsequential. While the focus of this research is on the relationships between women and their midwives, the relations that are important in the women's lives are also frequently heard throughout the discussion of the themes. Women spoke of needing to include their partners in their decisions to enter into midwifery care, of including their children in their birth experiences, of

their amazement at their deep love for their newborn child, and of the conflicts they may have experienced when announcing a decision to have a homebirth to family and friends.

Conducting the Research

The aim of this research was to illuminate the nature of the phenomenon of interest: the midwifery relation, through the development of rich descriptive accounts accompanied by interpretation of the meaning of the experiences. Hermeneutics is a creative activity, where meaning is created, not merely reported. While it is recognized that there are many perspectives on phenomenology, and its methods, for the purpose of this study, six research activities as described by van Manen (1990) were used in order to structure the project:

1. turning to a phenomenon which seriously interests us and commits us to the world;
2. investigating experience as we live it rather than as we conceptualize it;
3. reflecting on the essential themes which characterize the phenomenon;
4. describing the phenomenon through the art of writing and rewriting;
5. maintaining a strong and oriented pedagogical relation to the phenomenon;
6. balancing the research context by considering parts and whole (p. 30-31).

Data Collection

In hermeneutic phenomenology, data may take many forms. It is recognized that the data are not the experience of interest itself. However, each source of data sheds some light onto the understanding of the meaning of the experience. Sampling was purposive, each person and data source were

selected for their experience or their potential to reflect aspects of the experience (Baker, Wuest, & Stern, 1992; van Manen, 1990).

In this study, data were collected using a variety of strategies including conversational interviews, group discussions, written narratives, use of a reflexive journal, exploration of potential sources from etymology, literature, art and film, and observations of midwives and women in situations which may be informative of the relation (such as clinic appointments, home visits, prenatal classes and births). Both midwives and women were included in the study since this is an interactive phenomenon. For the purpose of this study, a midwife is an individual who identifies herself as a midwife who practices on her own authority (*autonomously*) and provides continuity of care to women who choose her as their primary care provider for their pregnancy, birth, and early parenting experience. Individuals who have midwifery education but are working as an employee in an institution or agency and providing adjunct care under the authority of a physician to women who are assigned to their care were not included. The midwives included in this study are Elizabeth, Madeleine, Kathleen, Perri, Rachel, Jacqueline, Anne, Brett, Elise, Blythe, Hilary, Maxine, Kira, Andrea, and Gail. These midwives represented the blend of midwives practising in Alberta. Some are in stable relationships, some have children, some have extensive post-secondary education, some have formal midwifery preparation, and others became midwives through apprenticeship. The women who participated in the study were receiving or had recently received care from a midwife who was practising in a way compatible to the definition of a midwife above. The women included in this study are Christie, Patricia, Cynthia, Heather, Alice, Chantal, Jane, Laurel, Janet, Adele, Meg, Theresa, Claire, Camille, and Aiden. In the chapter on the birth experience, other women: Diane, Lea, Molly, Cathy, Amy, Megan, and Irene are heard. These women participated in an earlier study on the women's experience of homebirth. The women were also representative of the blend of women who receive midwifery care in Alberta. Many of the women would identify themselves as representing the dominant

culture of Alberta, as "middle class," as reasonably well educated, and as part of a stable relationship. Some, however, would describe themselves as recent immigrants to Canada, as single mothers, or on welfare.

Settings

Data were collected in a number of settings. Most interviews were conducted in the participant's home. Observations occurred in the settings where the experience naturally occured: homebirths, hospital transfers, midwifery clinics, and prenatal classes.

Observation

I was able to observe midwives and women during prenatal appointments, prenatal classes, homevisits, and births. My role as an observer ranged from complete non-involvement to active participation in the activities occurring. In some situations my role was defined prior to the observation episode, in others, it evolved as the situation unfolded. For example, as an observer at a prenatal class, I initially watched the class proceed, however, toward the end of the class, the midwife and couples included me in the discussions. I did not take notes during my observations, however did write an account of the observation as soon as possible afterwards.

Conversational Interviews

I elected to structure my interviews as conversations. Conversation implies a discussion, which, like an interview, has a central focus, but is not one sided. I attempted to create an open atmosphere not unlike that which I use in my midwifery practice when meeting with new clients. My purpose was to enter into a relationship with the participant so that she would feel able to describe her experiences of the midwifery relation and her reflections of her descriptions. I began the conversational interviews by discussing the nature of my interest in the midwifery relation. When the conversations needed prompting, I used questions such as:

- When did you first start thinking of being (or using) a midwife?
- Tell me about your first visit with your midwife.

- What is it like to come to a prenatal appointment with a midwife?
- Can you tell me about an example of providing care to a woman where it was difficult to develop a relationship?
- How did others in your life respond to this experience?

All interviews were audiotaped and transcribed. In most situations, only one formal interview was done (see Appendix A for interview schedule). I had several informal conversations with most participants following the interview to clarify information or to confirm my interpretation of their experience.

Group Discussions

Following my initial review of the transcripts from the interviews, I conducted two group discussions - one with midwives and one with women who received midwifery care. The purpose of these group discussions was to further explore the question and to discuss some of my preliminary ideas regarding thematic analysis. These were lively discussions that were audiotaped. I reviewed the tapes as part of my writing and analysis but did not transcribe the tapes.

Written and Taped Narratives

In an attempt to access midwives' experiences in other jurisdictions, letters explaining the intent of the research were sent to practising midwives across Canada (as identified by their provincial midwifery associations) requesting written or audiotaped narratives which the midwife may feel are reflective of their experience of the midwifery relation. This request was also published in provincial midwifery newsletters, the MANA (Midwives' Alliance of North America) newsletter and the *Midwifery Today* homepage on the Internet. I received a few responses through e-mail only. These narratives were reviewed during the writing and analysis process.

Personal Journal

I kept a personal journal throughout the research process. I recorded personal impressions following observations and conversational interviews. I used the journal to reflect on my insights, ideas, values, beliefs, and biases. This

was particularly useful for analysis and for documenting the impact that the research process had on me, as the researcher.

Etymological Sources

These sources provide the origins and early meanings of particular words. Although the word now may not be associated with the origins, etymological enquiry may provide insight as to how words are tied to lived experiences from which they originated (van Manen, 1990). Where possible, word origins were explored from both a traditional perspective (e.g., Ayto, 1990) and from a women's perspective (e.g., Kramarae & Treichler, 1992).

Literature, Art, and Film

Because aesthetic forms are based on their creators' own lived experiences, they can be informative to the researcher. The aesthetic form transcends the actual experience and recreates the experience in a reflexive form (van Manen, 1990). The artist, writer, director may portray the experience as the centre of their work, as a background or incidental part of their work, or may present it in the macabre or purposely have the experience absent in the work. Literature such as *The Midwife* (Courter, 1981), *The Midwife's Advice* (Courter, 1992), and *Points of Light* (Sexton, 1988) are examples of literature containing descriptions of the midwifery relation. *The Good Earth* (Buck, 1931) is an example of literature where the midwifery relation is absent; the woman O-Lan gives birth alone. Collections of stories such as those in *Cradle and All* (Laura Chester (Ed.), 1989) reveal women's experiences with and without the midwifery relation. Art such as that included in Susan Bracaglia Tobey's *Art of Motherhood* (1991) and Judy Chicago's *Birth Project* (1985) portrays women helping other women through the birthing experience. Films such as *Waiting*, *Midwife, A Midwife's Tale* and *Born at Home* show insight into the lived experience of the midwifery relation. Some of the women shared birth stories or poems that they had written about their experiences, or photos or videos taken during their births. These revealed an additional dimension to their description of their experience.

Data Analysis

In hermeneutic phenomenology, the processes of data collection and data analysis occur together, rather than sequentially. Following each data collection episode, I used the process of intense reflection (Baker, Wuest, & Stern, 1992) to begin my understanding of this particular woman's experience. This reflection generally took the form of journal entries, discussion, or writing. These processes led me to additional questions that I asked at conversational interviews with subsequent women and midwives. In this way, it was possible to use the conversational interviews not only as a form of data collection, but also for reflective analysis.

Analysis of the data took the form of thematic analysis of transcripts, observations, and other text data. A theme is a phrase or statement that captures the meaning of the whole phenomenon from one particular perspective. This is not like a category where each category makes up a part of the phenomenon. Max van Manen (1990) suggests using four existentials as a guideline for thematic analysis: lived space, lived time, lived body, and lived relations. The purpose is not that the reader ought to be able to separate out one of the four existentials, but should at the end have some sense that the full scope of the lived experience has been described and interpreted. It is recognized that thematic analysis always reduces the meaning of the experience to that which can be known at the particular time in which the experience was captured or made static (van Manen, 1990).

The analysis process is a creative one, where meaning is created by the researcher (Smith, D., 1991). The process of writing and rewriting was undertaken in order to search for deeper understanding of the experience of the midwifery relation. The researcher is more involved in writing than the mere mechanics of reporting and describing the findings of the research. In writing, the researcher becomes engaged in self-reflection. The writing is aesthetic: evocative, expressive, creating space for reflection (Nussbaum, 1990).

The Use of Narratives or Stories

Each woman told me her birth story during her interview. Midwives, too, told stories - of their own births, of births they had attended or heard about, of other aspects of the pregnancy, birthing, and parenting experience. I listened as midwives used stories as a way of teaching, of explaining during visits and classes. As I began to search the literature - both academic and popular, I found many birth stories - some old and well known such as the Nativity, others personal such as those found in *Birth Issues*. Stories are an important part of this research. Narratives or stories are a way of making sense of and communicating one's sense of self and one's experiences in the world. Nancy Diekelmann (1991) suggests that narratives help us to "recognize our expertise, help us to know each other, transform our thinking, and help us in creating communities." (p.1) While some may argue that the contribution that narratives can make to understanding and knowledge is limited because they are too subjective, others such as Camilla Stivers (1993) suggest that "a narrative approach to self-understanding is not a distortion of reality but a confirmation of it" (p. 412).

I used narratives or stories throughout this research process. The use of narratives as a form of data collection can enhance the depth of understanding about a situation - there is never only one story to tell about a particular situation. As I began my analysis, I wrote and re-wrote stories based on interviews, observations, my own experiences, and other data sources. These stories contributed to the identification of themes. As I wrote, read and shared these stories, a deeper understanding of these experiences was revealed to me. Some of these stories have remained intact in the written descriptions of the research. Others have melted into the writing, no longer needing to stand on their own.

Considerations of Rigor

In qualitative work "rigor is less about adherence to the letter of rules and procedures than it is about fidelity to the spirit of the qualitative work" (Sandelowski, 1993, p.2). In hermeneutic phenomenology, the research is concerned with intersubjective knowledge, meaning that is constituted through

dialogue with careful attention to the historical and present contexts of the phenomenon. Strict adherence to criteria for validity and reliability for qualitative work based on empirical criteria such as those developed by Lincoln and Guba (1985) may detract from the discovery-oriented approach of hermeneutic phenomenology (van Manen, 1990).

Bracketing is often identified as a method of improving rigor used in forms of qualitative work (Baker, Wuest & Stern, 1992; Field & Morse, 1985; Ray, 1994). Bracketing is a mathematical term used to describe a process where the researcher sets aside her own knowledge, beliefs and values related to the research topic. The idea behind bracketing is that the researcher's own perceptions may bias or influence the analysis, with the researcher trying to find confirmation of her own perception within the data, rather than allowing the meaning to emerge from the data (Hutchinson, 1986). This practice is also based on the assumption that it is possible to clearly identify all the potential influences within one's knowledge and expertise, to separate these completely from all other thinking, and to maintain this separated state for long periods of time while completing the research project. Others (e.g. Bergum, 1991; Smith, D., 1991; van Manen, 1990) argue against the use of bracketing in hermeneutic phenomenology. They suggest that the preconceptions of the researcher are part of the research data, to be explicitly identified and reflected upon. David Smith (1991) bases the argument against bracketing on the works of Husserl, Heidegger, and Gadamer. Thinking and reflecting do not occur in isolation to the events of the world; thinking and reflection occur within and are about the events of the world. The knowledge, experience, and "prejudgments" of the researcher are necessary elements to the reflective process.

Max van Manen (1990) suggests using a more aesthetic approach to rigor. The criteria he suggests are: a strong and oriented text, richness in the description of the midwifery relation, and depth into the possibilities of the midwifery relation. A good phenomenological description is one where "we recognize an experience as one we have had or could have had" (p. 27).

These criteria are congruent with directions for rigor within feminist research (Hall & Stevens, 1991). Within feminist criteria, one must ask whether the answers in the research are for women. Through adhering to the directions to discover and validate through lived experience, I am reminded that my purpose was to find an understanding of women's experiences that will be for women. Through ongoing validation with the participants of the research, frequent discussions with my advisor, and with other researchers in the area of human relations, I attempted to remain sensitive to the question of whether the research will contribute to the exploitation or oppression of women. I used a reflective journal throughout the research process to attempt to uncover my own biases, interests, and influences. My own experience is also part of the written account of the research. For this research, I chose to enter reciprocal relationships with women in order to understand the world as seen through their eyes rather than construct how the world is observed from the outside. I have documented the research process in this report as a way of demonstrating the dependability of the research and the adequacy of the process to answer the research question (Hall & Stevens, 1991). Anne Opie (1992) suggests that the validity and reliability of research may be reflected in the way in which the voices of others are reported. In my written report, I have carefully select quotes from the conversational interviews, including contextual aspects of the conversation where this contributes to a fuller understanding of the words.

Ethical Considerations

Because this research involves human participants, I sought ethical approval within the Faculty of Nursing. Although none of the midwifery practices in Alberta have research ethics procedures, I discussed my research interests with midwives, women, and representatives of a consumer group before I began to recruit participants for the study.

I used a variety of strategies to recruit participants including advertising, letters, and referrals from participants (see Appendix B). In all strategies, women were given information about the study, including how to contact me and my

supervisor, and how to withdraw from the study. Informed consent was obtained from each participant (see Appendix C).

Wherever possible and desired by the participant, I provided participants with copies of transcripts and validated my ongoing and final analysis of the data with them. I honoured requests not to include particular stories or quotes from the transcripts in the final report of the research.

In this study, there are some particular ethical issues that needed to be considered. Birth is a highly personal event during which women may feel very vulnerable. I needed to remain sensitive to women's experiences during their births so that I would recognize if I should not be present. Because of the nature of the research, midwives and women were asked to reflect on their experiences. These reflections may change the nature of the experience for them. The impact of the research on participants is not limited to the period of the study; reading or hearing about the study in the future may also cause renewed reflection that may never have occurred if she did not participate in the study. My ethical commitment to these women must extend beyond the study (Bergum, 1991).

Because the midwifery community is small, it was inevitable that the midwives and some women who participated in the study were well known to me. Although this was an advantage in that I already have a close relationship with these women and therefore may have been trusted as a researcher early in the research process, there can also be ethical concerns. Participants may not have been willing to share intimate information with me knowing that I will continue to have professional or friendship relations with them long after the research has concluded. I may have felt constrained in asking particular questions of some participants because of my relationships with them. External readers of the research may question the accuracy of the research knowing my relation to many of the participants. In addition, I was the president of the Alberta Association of Midwives for two years during the study period. Because we were and continue to be in a critical time for legislation, some midwives may have felt somehow obligated or reluctant to participate in the study because of my position. In order

to address these concerns, I attempted to be open about them when recruiting participants and to ensure that all participants were aware that they could discuss concerns or wishes to withdraw from the study with my advisor. It was important for me to remain consciously aware of these ethical questions throughout the study process, constantly reflecting on these potential influences.

The size of the midwifery community and the nature of the relationships that develop among midwives and women experiencing midwifery care brought along additional challenges of maintaining confidentiality. Many of the stories I heard through this research process are highly identifiable within this community. Some women were not only comfortable with openly sharing their stories, but wanted to have their actual names attached to the stories. However, because I was not able to obtain consent for this level of identification from everyone involved in the story (e.g., a midwife or family member), I chose not to use actual names for any of the participants. In some situations, the context of the story is what makes the woman or midwife identifiable. In these situations, the context has been altered. In some situations, it is a combination of events that makes the woman or midwife identifiable. In these situations, the woman's or midwife's voice may be heard from two or more names, separating the identifying circumstances.

Summary

The question addressed in this research - *what is it like to be with woman?* - arose from my interests and experiences in providing care for women during their childbearing experiences. Hermeneutic phenomenology was selected as the most appropriate method for this research because it is grounded in life experience, it allows for a range of data sources, it accommodates the inclusion of personal experience, and it results in a text that may provide others with an understanding of the experience of being with woman. In research, the meaning of this experience is explored in depth in order to come to an understanding. However, the research must always remain within the context of everyday life

(Bergum, 1991). In the next chapter, I will describe the context of midwifery in Alberta at the time of the research.

Chapter Two

Fuelling the Midwifery Fires

In the Canadian cartoon *For Better or For Worse* (Johnston, 1991, p.79), Ellie who is expecting her third child, tells her husband John that she is thinking about having a homebirth with a midwife. She explains that she is not sick and that women have been doing this for hundreds and hundreds of years. His response is "*I just don't want to try anything new!*"

Flashback

Although some scholars (e.g., Rich, 1986) suggest that early in human history, women gave birth alone, particularly until men recognized their fatherhood, others (e.g., Trevathan, 1987) suggest that seeking assistance in childbirth has been an important part of the survival of the human species. In contemporary cultures where women appear to give birth on their own, it is generally the practice for an older experienced woman to observe from a distance and provide support and assistance should complications arise. Wenda Trevathan (1987) suggests that the midwife - the helper in matters of pregnancy, birth, and mothering is at least a million years old.

Midwifery Practice in Alberta

If Ellie decided to use a midwife, what would she experience? Midwives in Alberta (and other provinces) usually work with at least one other midwife in a partnership or collective. Some midwives practice alone, out of choice or circumstances. While some midwives have an informal structure to their practice where women drop in at the midwife's home for prenatal advice, most have "clinic hours" and a designated office space (Mason, 1988). Ideally, a woman begins prenatal care with her midwife early in her pregnancy and will continue to see that midwife or small group of midwives at regular intervals throughout her pregnancy. Many midwives include prenatal classes and homevisits as part of their prenatal care. Midwives attend the woman's birth, usually from the beginning of active labour and staying 3-4 hours after the birth. They also provide postpartum care, commonly for 6 weeks.

Flashback

When European settlers came to Canada, most had to use their neighbours for assistance during childbirth. There were no prenatal clinics or office visits. A woman might visit her neighbour for advice about pregnancy or childrearing concerns. The knowledge shared was based on local conditions - what was available locally, what was accepted locally. Eventually, some women became identified as the "midwife" for a particular community because of their knowledge and expertise. The midwife was able to base her care on her knowledge of a particular woman and her family within the context of her whole life and her community (Mason, 1988).

Continuity of care is considered to be one of the most important aspects of midwifery in Alberta. Women who receive medical maternity care have a number of providers, many of whom are strangers e.g. their primary care physician, case room nurse(s), postpartum and nursery nurses, interns, residents, dietitians, public health nurse(s) and prenatal instructors. Women choosing midwifery receive all their care from their primary midwife or from a shared care group of midwives[1]. In addition to her scheduled visits, the woman is welcome to contact her midwife by phone or pager when questions or concerns arise. Other elements of midwifery practice: informed choice, woman centred care, family involvement, wholistic care, and appropriate use of technology have evolved through the strong belief in normal birth and through the partnership between women (and families) and midwives in defining what a midwife may be.

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[1]Shared care midwifery generally consists of two or three midwives who work closely together to provide care to a particular woman. In some situations, all the midwives in the shared care group will be present at each prenatal appointment, attend the birth, and provide postnatal homecare. In other situations, there may be a rotation of midwives so that the woman has each prenatal appointment with one of the midwives. In this situation, the midwives meet regularly to ensure that they share their knowledge of the woman. The midwives also must ensure that there is a balance in the appointments so that the woman has opportunities to meet and get to know each of the midwives in the group. In shared care practices with two midwives, both attend the birth, perhaps taking turns being the first to be called. In shared care practices with more than two midwives, there may be an on-off call schedule so that only the two midwives on call will attend a woman's birth.

Flashback

Social changes in the 1960s including the back-to-the-land movement, the woman's movement, an interest in eastern spiritual concepts, and popular psychology created an environment that helped to nurture the "re-birth" of midwifery in Canada (Barrington, 1985). Families expected increased involvement and control over pregnancy, birth and parenting experiences. While gradual concessions were made within the healthcare system e.g. "allowing" fathers to attend the birth and putting wallpaper up in hospital labour and birthing rooms, the power and control remained in the hands of the professionals and pregnancy and birth remained a medical event.

Women and families began to seek radical alternatives to the healthcare system for their birthing needs. Sympathetic physicians or friends and neighbours were found who would do homebirths. The idea of midwifery evolved through this search for alternatives to the norm, not because there was a group of professional midwives out there, ready to offer their services. The title midwife was earned. Women did not call themselves midwives until they were labelled as such by others in their community. The definition of midwifery evolved from local expectations for alternative care.

Women seeking midwifery care may find out about midwifery in a variety of ways. In the past few years, telephone companies have agreed to include a midwifery section in their yellow pages. Most midwives or midwifery practises purchase a listing. Midwives also advertise in stores, schools, and various newsletters. In Alberta, local consumer groups (e.g., The Association for Safe Alternatives in Childbirth in Edmonton) provide information about midwifery to anyone who inquires. However, most midwives claim that the majority of their clients come to them by word of mouth - through recommendations of friends and family who have experienced midwifery care.

Flashback

It is likely that the first "new" Canadian midwives began in the Kooteneys in British Columbia in 1972. At the time, midwifery was a secret - passed along by word of mouth. Midwifery remained "underground" until the late 1980's (Barrington, 1985).

Midwives support the woman in her choice of birthplace. However, for women who wish to have her midwife as her primary care provider for her birth, the choice is limited to home. Midwives who are not yet regulated do not have hospital admitting privileges. Consequently, most midwife attended births occur at home. Usually two midwives attend homebirths, in part to assist one another and in part to be prepared to safely deal with emergencies. Midwives come to homebirths with supplies and equipment for the birth (e.g., fetoscope, doppler, stethoscope, sterile gloves and instruments) and for common emergencies or complications (e.g., intravenous fluids, oxytocic drugs, suturing supplies, oxygen and resuscitation equipment). Most midwives keep current their emergency skills such as neonatal resuscitation and cardiopulmonary resuscitation. Some midwives also provide supportive care to women who choose to have a hospital birth with a physician.

Flashback

Prior to the mid-nineteenth century, literally all births occurred in the home. By 1920, the cultural norm of hospital birth with a physician was well established (Benoit, 1991) even though hospital births were accompanied by an increase in perinatal mortality (Oppenheimer, 1991; Strong-Boag & McPherson, 1991). By the mid-twentieth century, literally all births occurred in the hospital. There are various reasons for this change e.g., urbanization, poverty, and changes in physician power and practices. During this transition, physicians and nurses promoted physician attended hospital birth and actively campaigned against midwifery attended homebirths. It was a self-fulfilling prophesy. Many women had no access to experienced maternity care either because physicians had not yet established in those communities or because midwives were afraid to practice. Women were forced to turn to inexperienced assistance for their births. The lack of expert attendance at births, primarily in rural areas fuelled the fire against midwifery. Physicians were able to use poor outcomes as "evidence" that medical care is superior and necessary (Benoit, 1991). Women who may have found childbirth without the trusted midwife a frightening experience began to accept the alternative of physician attended birth in hospital (Mason, 1988).

Midwives do not view homebirth as being an unpleasant but necessary choice given the constraints of the healthcare system. Midwives promote homebirth as

a safe choice (Kitzinger, 1991). While women are usually able to find evidence to support the safeness of their choice of homebirth (e.g., Tew, 1995), they often experience criticism from friends, family, healthcare providers and strangers.

Flashback

Perinatal mortality rates were very high in the 19th century. The high death rates were often blamed on midwives and homebirth. In reality, deaths were likely the result of conditions accompanying industrialization such as poverty, disenfranchising, poor nutrition, unsafe working conditions, and poor sanitation (Benoit, 1991). In fact, available statistics suggest that the highest death rates occurred in non-midwife attended births (Mason, 1988).

With the exception of Ontario, midwifery services are not covered by provincial healthcare funding. Women and families are responsible for paying the full fee which ranges from $800-$2000 depending on the particular practice and community tolerance for two tiered health care. Midwives struggle with finding a balance in an acceptable fee. They recognize that too high a fee puts midwifery out of reach for many families, but too low a fee ultimately puts them out of business. Midwives must cover all their expenses from this fee e.g. office, supplies, equipment, transportation, communications, and insurance. Most midwives, even those working "full time," report a taxable income that would be considered below the poverty level. Midwives are flexible in how they expect their fee to be paid, accepting deferred payments, sliding scale fees, and barter. Most midwives also provide care to a small number of women from whom they do not expect any payment. These are most often women living in poverty, on welfare, or in very transient conditions. Even so, some families feel they cannot choose midwifery because of the cost. This erratic income has lifestyle implications for midwives. For example, vacations are rare. Planning a vacation requires nine months of foresight and an understanding that taking a few weeks off may mean losing more than a month's income.

Flashback

In some earlier societies, midwifery took on a somewhat professional character with various levels of formal education, hierarchies within the midwifery community, and an expectation of receiving payment for services. In some cases, midwives were able to earn a very comfortable living through their work. For example an English midwife, Hester Shaw, was said to have been paid £1000 for a birth in 1666 (Brooke, 1995). The first "pioneer" midwives in Canada were often widows who turned to midwifery to support themselves and children (Benoit, 1991). Midwifery was one of the few acceptable ways that women could work for wages. Even so, the remuneration system was erratic. Midwives frequently accepted barter for attending births. The midwife did not set the price for the birth. Rather, the family paid what they believed was the "right" price. Midwives attended all women who asked for their services (Ulrich, 1990). In many cases, the midwife attended women who could not pay at all. Even in wealthier communities, midwives tended to be "poor."

With the exception of one male in Ontario, Canadian midwives are women. Many woman say that they consider midwifery because they want a female provider for their pregnancy and birth.

Flashback

Throughout history, midwives have been women. We know that the deities responsible for childbirth in Greek and Roman mythology were female - Gaia and Aphrodite in her form as the divine midwife Ilithyia (Tobey, 1991). There is evidence of only two cultures, the inhabitants of Yap and Easter Islands, where the assistant of choice is a male - usually the father of the baby (Trevathan, 1987). Birthing remained women's work until the 16th - 17th centuries. Many theories have been developed for this long lasting trend. In various cultures and religions, taboos associated with women's bodily functions meant that contact with menstrual and postpartum blood, and breastmilk is avoided by men. A second theory is that while it was recognized that women had a far greater understanding of the female reproductive system and of the birthing process, work in birthing was considered to be beneath men - only suitable for women (Rich, 1986).

Most entered midwifery life in their mid thirties and most are well educated - many have a minimum of an undergraduate university degree (Barrington, 1985). While many of the first midwives in the 1970's had to learn midwifery on their

own, most midwives now have had an apprenticeship style of education and/or formal education in another jurisdiction or at the University of Alberta Advanced Practical Obstetrics or Nurse-Midwifery Programme.

Flashback

While there were formal education opportunities for midwives in some cultures, early Canadian midwives learned their knowledge and skills through an informal apprenticeship where younger women helped the midwife (Benoit, 1991). In keeping with the status of women at the time, many of the midwives were illiterate. It was unlikely that midwives were able to exert any form of "professional dominance" because women had very little social power.

Some were mothers before finding midwifery, others sought motherhood because of their midwifery experience, some are childless. For most, midwifery is considered both a calling and a lifestyle which is seldom economically wise.

Flashback

It is most likely that the first birth attendants were female relatives, possibly the woman's own mother. The most common form of midwifery has been the neighbour or village woman who became identified as the best birth attendant, the woman who had the healing touch, the comforting voice, the knowledge of the birthing process and of the herbs and techniques that could be used to help. Perhaps those women had an interest midwifery and developed those skills in order to be seen as the good midwife. Perhaps those women were called to midwifery by their community and developed those skills to survive. What is known about those early midwives is that they were generally older women who had already raised their own children. While some young girls may have attended births with their mothers or aunts as an apprentice, their apprenticeship would not be complete until they had the experience of mothering themselves (Gedge, 1994; Trevathan, 1987). In early Canadian communities, the "real" midwives were older women who had experience in childbearing (Benoit, 1991).

Midwives come from a variety of backgrounds and provide services to women from many cultural, social and economic groups. However, midwives and their consumers are often stereotyped as "hippies," "granola crunchers," or "anti-technology." Alternatively, because midwifery consumers pay for midwifery

services, they are also stereotyped as "yuppies" - well educated, professional, upper-middle class women, generally representing the dominant culture of the province.

Flashback

Midwives have frequently been associated with negative images - e.g. toads (Lubell, 1994), witches (Barstow, 1994), and dirty drunk women like Dicken's Sairey Gamp (1907). Because of the roots of "new" midwifery, a caricature of the hippy midwife developed. I remember being at the airport in Toronto waiting for the bus to the city in the early 1980s and noticing a group of women dressed in long cotton skirts with fringed scarves around their necks, wearing Birkenstock sandals, long granny braids, and carrying large carpet bags. The man next to me joked that this must be a 60s reunion, costumes required. I joked back that it must be a convention of midwives. Much to my surprise, as the bus they all boarded pulled away, the sign on its side said "Welcome to the Midwives Alliance of North America Toronto Conference."

Unlike the granny midwives of the past, midwives most commonly work in urban areas where medical services are readily available. There are several reasons for this. With the exception of the Kooteneys in British Columbia, it was in the urban centres that the interest in midwifery came about in the 1970's. In Alberta, Sandra Botting in Calgary, soon followed by Sandy Pullin and Noreen Walker in Edmonton were the first, and for many years, the only midwives. Midwives also tend to practice in urban centres where there are enough births to ensure that the midwife can earn an adequate income to cover her expenses. Some midwives do provide services for women in rural areas, frequently travelling distances of 4 or more hours.

Flashback

Because of settlement patterns in Canada, the catchment area for a midwife's practice tended to be geographically large, with clients widely dispersed. Midwives were expected to travel long distances in any kind of conditions. We are all familiar with the Canada Post television advertisement featuring the midwife and her apprentice travelling by sleigh and finally on foot in a blizzard. The midwife was never sure what she would find when she arrived at a home - the family may or may not be well prepared for the birth (Benoit, 1991; Biggs, 1991).

Until recently, the practice of midwifery has been "alegal" in most provinces. This means that there were no laws specifically regulating midwifery, nor were there laws specifically preventing the practice of midwifery. In many provinces, however, the Medical Act included "midwifery" as part of the scope of practice of medicine. Therefore, it could be possible for a midwife to be charged with practising medicine without a license.

Flashback

In 1990, Noreen Walker, an Edmonton midwife, was charged with practising medicine without a license for attending an uncomplicated homebirth near Red Deer, Alberta. The first crown prosecutor assigned to the case resigned after listening to testimonies which stimulated for him, strong emotions about the negative aspects of his wife's birth experiences in hospital. A second crown prosecutor was assigned and the case continued. The judge ruled that midwifery was not the practice of medicine (Williams & Levy, 1992).

In addition to the potential constraints that may arise through alegal practice, midwives are further challenged through their lack of recognition within the healthcare system. While most midwives have worked at getting cooperation from physicians, public health nurses, and hospital staff so that women are able to access necessary care without being "punished" for their choice of midwifery and/or homebirth, these are uneasy alliances. Midwives all have stories of experiences within the healthcare system where they have been ignored or disbelieved. Women have stories of inappropriate care received in the

healthcare system once they identify themselves as being midwifery clients (e.g., Pauly, 1996).

> ***Flashback***
>
> *In Ontario, a cottage hospital system was attempted in order to decrease perinatal mortality rates. Based on the Scottish model, these hospitals would be set up in small communities and staffed by salaried birth attendants. Nurses and physicians were successful in shutting midwives out of the cottage hospital system. They "maintained that midwifery was an outdated occupation belonging in the 'dark ages' and unnecessary in an 'up-to-date' country such as Canada" (Benoit, 1991, p.44).*

Misinformation about midwifery is common. For example, newborn deaths known to have been caused by congenital abnormalities have been attributed to poor care by the midwife. A brochure about maternity care widely distributed in physician's offices by the Society of Obstetricians and Gynecologists in Canada informs readers that midwives are paid approximately $1000 per birth where physicians are only paid approximately $200 per birth. The information that is not included in this brochure is that the physician fee only covers the short period of time that they are present for the actual delivery of the baby. They are also able to bill for prenatal care, postpartum care, and many other services that may be provided. The midwife's fee covers all of the care provided by the midwife, some of which would not be provided by a physician e.g., labour care.

Flashback

Even though the 1806 Upper Canada Medical Act supported midwifery practice, midwives were publicly criticized by the medical community. When a life was lost in a midwife attended situation, the midwife was blamed for her stupidity. When a physician lost a life, the loss was explained by science (Biggs, 1991).

*The **Canadian Mother and Child**, a publication of the federal government contained the following statement in 1943: "If you have to rely on the services of a neighbour, or so-called midwife for your confinement or aftercare, make sure that no illness exists in her family, and that she is not connected with a febrile case elsewhere, and above all, see that she herself is healthy, clean and tidy" (Couture, 1943, p.50).*

In order to meet the challenges of alegal practice, exclusion from the healthcare system, inadequate income, and limited accessibility, midwives in Canada have sought legislation to be recognized as legitimate healthcare providers. Ontario is the first province to have fully regulated, fully implemented and fully funded midwifery. Not all midwives or midwifery consumers supported the move toward legislation (Van Wagner & Lee, 1989). Many worried that legislation would result in a new professional monopoly governed by the rules of the medical community (Mason, 1988). Some viewed the extreme control of midwives by nursing or medicine in jurisdictions such as the United Kingdom and Australia as the future of midwifery in Canada if legislation was pursued (Brooke, 1995).

Flashback

While women were responsible for midwifery work, they were often accountable to or controlled by the dominant powers of their culture. For example, in the middle ages, the Christian Church dictated that the midwife's priority in attending birth was to baptize the child, not to provide comfort to the woman (Rich, 1986).

In Alberta, the midwives formed the Domiciliary Midwives Association registered under the Societies Act. They approached the government to request funding for midwifery services. At the same time, the government was aware

that the Alberta Association of Registered Nurses and the Western Nurse Midwives Association were interested in clarifying the role of nurses in childbirth as outlined in the Nursing Act. The Domiciliary Midwives Association and the Western Nurse Midwives Association were told that the government would not address requests for midwifery legislation or access to health insurance funds unless the two groups amalgamated. The membership of both groups agreed to join, however, the final union took several years to complete. Some of the executive of the Western Nurse Midwives Association resisted releasing their funds to the midwifery associations in the three provinces (British Columbia, Alberta and Saskatchewan) covered by the association. The initial union occurred through the development of the Alberta Midwifery Task Force. The membership of the Task Force consisted of midwives and consumers. Its mandate was to lobby for midwifery legislation. In 1986, the Alberta Association of Midwives was formed. Its mandate was also primarily to lobby for midwifery legislation, however, the development of standards of practice and midwifery education recommendations were among the tasks accomplished in its first years. Despite the amalgamation of the nursing and non-nursing midwifery groups, the nursing community continued to resist accepting that midwifery is not a sub-specialty of nursing (Advanced Maternity Practice Working Group, 1994; Alberta Association of Registered Nurses, 1987 & 1991).

Flashback

In 1897, the National Council of Women created the Victorian Order of Nurses (VON) to celebrate Queen Victoria's Jubilee. The purpose of the VON was to provide care where medical services were not available. Since one of the biggest needs was for care during childbirth, the superintendent tried to include midwifery preparation as part of the nursing training. Initially, the medical profession opposed the idea of the VON altogether. The Nurses' Association of Canada was not supportive of including a midwifery role because of the "housework" component of midwifery which did not fit the current model of professional nursing practice. The medical community agreed to support the VON once the National Council of Women eliminated midwifery from the scope of VON practice and promised to ensure that the nurses would only help the physicians and not replace them (Laforce, 1991; Mitchinson, 1991). Nurses continued to actively campaign against midwifery "preach[ing] the gospel of medical birth" (Mason, 1988, p.113; Ontario Midwifery Task Force, 1987) and ultimately replaced midwives as the woman helper in childbirth. Physicians were more comfortable with nurses because they were less autonomous in their practice than midwives and more willing to take a subservient role to physicians (Benoit, 1991; Biggs, 1991; Mason, 1988).

In 1990, the Alberta Association of Midwives (AAM) and the Alberta Midwifery Task Force (AMTF) made submissions to the Health Disciplines Board. Following a review of the submissions, the Minister of Labour agreed to further investigate midwifery legislation. The Midwifery Services Review Committee was struck. It was made up of representatives of the AAM, AMTF, AARN, College of Physicians and Surgeons (CPSA) and chaired by Dan Charlton, a representative of the Professions and Occupations Bureau. As part of the process of exploring whether to recommend the legislation of midwifery, the committee commissioned Peat Marwick Stevenson & Kellogg (1991) to study the feasibility of including homebirth in the scope of midwifery practice. While the concept of midwifery legislation was slowly gaining acceptance, homebirth was an entirely different issue (Burtch, 1994; Thompson, 1989). Emily Martin (1987) explains the resistance to homebirth by suggesting that homebirth is like a strike against the industry of obstetrics. The final recommendations of the Peat Marwick report supported home as a safe choice of birthplace. The report of the Midwifery

Services Review Committee (Alberta Labour, 1992) recommended the inclusion of midwifery under the Health Disciplines Act, the development of regulations to govern autonomous direct-entry midwifery practice, baccalaureate education for midwives, and choice of home or hospital for birth. In July 1992, the Alberta Legislation amended the Health Disciplines Act to include midwives as one of the professions which fall under its jurisdiction.

Flashback

The presence of men in birth art began around the 17th century (Rich, 1986). This coincided with a general decrease in the freedom that women had in society in Europe and an increase in status of the medical profession (Arms, 1994). It is also at this time that the persecution of persons accused of devil work or witchcraft was well established in Europe and America. The majority of those tortured, drowned or burned were women, many of whom were considered to be healers or midwives. There is much written about the "burning times" - some with scientific explanations, others with critical analyses of the impact of power on society (Arms, 1994; Barstow, 1994). What is clear is that this period marked a dramatic change in the role of midwives. Where midwives had been valued and necessary in societies, they became at best, a suspicious necessity and at worst, a group to be continually persecuted or eliminated. Some might argue that midwifery benefitted from this change because formal midwifery education and licensing processes evolved in some jurisdictions. However, education and licensing fell under the direct rule of physicians and very few women were actually able to access education.

In January 1993, the Midwifery Regulations Advisory Committee was struck. This committee included representatives of the AAM, AMTF, AARN, CPSA, Alberta Hospital Association, Alberta Public Health Association and was chaired by Dan Charlton. The mandate of this committee was to develop the *Midwifery Regulation* (1994), *Standards of Competency and Practice* (1994), *Recommendations for Education and Assessment* (1994), and to design a process to determine the registration eligibility of the first group of midwives to apply to the Professions and Occupations Bureau for midwifery registration. An important inclusion in the Standards of Competency and Practice was a philosophy and principles section. Both midwives and consumers were

concerned that something about the essence of midwifery would be lost in reducing midwifery to a list of rules and knowledge and skill competencies.

Flashback

An attempt to outlaw or restrict midwifery practice began in the late 18th century when the Upper Canada Medical Act of 1795 defined midwifery as part of the practice of medicine. The practice of medicine was restricted to licensed physicians and individuals who had university degrees or who were navy surgeons. This act was repealed in 1806 because physicians were not able to meet the needs of all women and no midwives had or were likely to attain university degrees (Benoit, 1991; Biggs, 1991).

A series of medical legislative changes in the 19th century further threatened the ability of midwives to continue providing care. For example, in 1865, a provision was made to the Upper Canada Medical Act to require midwives to pass a licensing exam within one year. After 1874 when orthodox, eclectic and homeopathic practitioners amalgamated under one medical act, public debate of the status of midwives under medical acts intensified. By 1895 when the opposition party in Ontario unsuccessfully attempted to introduce a professional free trade bill which would end the medical monopoly, it was clear that both government and the press were highly influenced by the medical profession and neither supported midwifery (Biggs, 1991).

The Regulations, Standards and Recommendations were endorsed by a Standing Policy Committee of Cabinet in November 1994 and the Midwifery Regulation went into effect on August 1, 1995. However, the registration assessment process was not developed in time for registration of midwives to occur prior to August 1, 1995. While officially, the Regulation is in effect, there is no political will to enforce the Regulation until the first midwives are registered. Once the Regulation is enforced, only registered midwives will be permitted to practice or to use the title "midwife."

Flashback

After the elimination of midwifery, its practice was permitted for many years in isolated communities in Newfoundland, Labrador and the north. The services were provided by midwives imported from countries like England or by nurses who received additional training through courses such as the Advanced Practical Obstetrics course at the University of Alberta and the Outpost Nursing Course at Dalhousie University to provide intrapartum care in cottage hospitals or nursing stations. Many "foreign-trained midwives" found it difficult to work in isolated communities in Canada (Benoit, 1991; Mason, 1988).

The only exception to these restrictions are First Nations midwives. While they are welcome to enter into the provincial regulation process, they are not required to do so.

Flashback

The government tolerated midwifery care in First Nations communities up until the early 1970s. The Federal Medical Services Branch developed nursing stations in or near First Nations communities and strongly encouraged women to come in off the land and have their births in the nursing stations under the supervision of midwives and nurses. In an attempt to make birth "safer," a policy requiring all pregnant women to be evacuated to large urban centres for their births was enacted by the end of the 1970s (Mason, 1988). By this time, most communities no longer had traditional midwives practising or teaching their skills to younger women. With the evacuation policy, nursing station nurses did not necessarily have midwifery skills. Aboriginal women had few choices but to agree to evacuation. Aboriginal midwifery has a rich history but is nearly absent in "western" literature. The midwife was highly respected in her community (personal communication with Anne Bird, April, 1996). We occasionally catch glimpses of the traditions of Aboriginal midwifery. One of the characters on the Canadian drama ***North of 60*** *is Elsie, the community wise woman - healer and midwife. Elsie officially does not practice her skills, the health of the community is the responsibility of a Federal Medical Services nurse. However, when Ellen, wife of Peter, the Band's chief, decides that she does not want to be transported to Yellowknife or Edmonton for her birth, Elsie agrees to help her. When we listen to Elsie's words to the nurse, to Ellen, to Peter, we hear her confidence in the woman, in nature - even though this baby is in the breech position.*

The registration assessment process consisted of an application, a portfolio review, written and practical exams. The exams were completed in August 1996. It is expected that the first midwives will be registered sometime in the late spring of 1997. Many issues including the funding of midwifery practice, access to health care resources such as hospitals and laboratories, and the level of control that regional health authorities will have over midwifery practice are yet to be resolved. It is expected that registration will cost each midwife approximately an additional $6000 per year to cover registration fees and insurance. Some midwives will be unable to afford these costs and may be forced to stop practising.

Finishing Ellie's story - Fuelling the fires

Ellie did not choose to have a midwife. She did however, have a homebirth - a politically correct homebirth. Her birth occurred in the midst of a freezing rain blizzard in April. She didn't have time to leave, the roads were unsafe. She was helped by a neighbour who is a nurse, her two children and a young man who delivered pizza. Her partner John, the police and the paramedics arrived after the baby. Later, John tells Ellie that she was lucky that things worked out well, that she should have gone to the hospital. She tells him that she knows that she should have, but "it's nice to have had her in the privacy of our own home" (Johnston, 1991, p.109).

Ellie's story is an interesting illustration of the state of midwifery in Canada. One of the strongly burning fires is that of the particular services that midwives provide to women. These services are built on a strong belief that pregnancy and birth are usually normal, healthy experiences that belong to the woman and her family. The other fire, equally strong, is the fears about midwifery. At points in history, midwives were actually burned in those fires. At other times, midwives felt the heat of those fires in the words and actions of influential people who attempt to eliminate or control midwifery. Why is it that Lynn Johnston chose not to bring a midwife into her story of Ellie and John's new

baby? Was this too big a risk for a popular cartoonist in North America? This is the context in which the midwifery relation is lived.

In the following five chapters, the question - *what is it like to be with woman?* - will be addressed. Each chapter is a theme, a particular way of looking at this question. The themes: setting the tone for the relation, trust, the birth experience, friendship, and awakening to our woman-selves are interwoven. In some ways, the discussion of the experience in themes is arbitrary - the experience is of the whole, not of a particular view on the whole. And yet, the themes can be informative. These themes called attention to themselves while I spoke to women, while I observed visits and births. They are an important part of coming to understand.

Chapter Three

Setting the Tone for the Relation

As the woman and midwife begin their relation, a tone is set. When we think of tone, sounds, music and colours come to mind. Tone is a special style or tendency that permeates the morals and manners within a community. (*Oxford English Dictionary*, 1990). The tone permeates. Whether this is a conscious awareness or buried into the recesses of our experiences, the tone has an influence on our thoughts, actions, and decisions. In this chapter, the tone of the midwife woman relation is described - a first visit, a decision to commit to midwifery care, a midwife's struggle with telephone conversations with women she has not yet met. There is also a sense that setting of this tone occurs throughout the relation between the woman and the midwife, at times perhaps a monotone - constant and boring, yet safe and comfortable; at others, perhaps vivid and exciting. This chapter, setting the tone for the relation, sets the tone for the other themes as well. The tone of the relation permeates this experience of being with woman. The tone opens the possibilities for trust, friendship, birth experiences and awakening to our woman-selves.

Cynthia - Making our own decisions

> *I felt like I had sort of been conned the first pregnancy to go along with anything they wanted. It took a little bit of time to convince my partner Darryl that a homebirth with a midwife was a good choice. He was uneasy about it, and I let it go because I wasn't going to be able to do it unless he was comfortable with it. I just started discussing with him some of the things that I was finding in "Reclaiming Birth." Not as, "Oh, gee we should have a homebirth" but "look at what I read" and then he said, "oh, we should go and talk to someone about having a homebirth."*
>
> *So I phoned a friend who had a home birth. I asked her which midwives she had used and she said "Joanne and Karen" and told me about each one. I figured that I would like to meet Joanne and that's what happened. I just phoned her up the next day and made an appointment and we didn't look back after that.*

The first visit was nice. It was very relaxed and Maureen, the apprentice was there but there was no obligation to have her stay if we didn't want. Darryl and I agreed before we went that we would meet Joanne and we would discuss whether we wanted to go this route and then get back to Joanne. But by the end of the interview, I was convinced that was the way to go. I'd just come from an appointment with the obstetrician where it was like we were herded through like cattle - there was no time to answer questions.

We spent at least an hour with Joanne at the first visit. I had a big list of questions. There seemed to be nothing that she couldn't answer. She talked about the number of people who had a homebirth, and the number who succeed in having a homebirth and it was very high. She talked a little about the sort of equipment she has and how she prepares for a homebirth. It was really premature to get into what she actually has at a birth, but we had a few questions about that. We just spent a lot of time talking about the experience we had the first time. And, the concerns - the things that were probably seen as complications the first time that I didn't know if they were going to cause a problem the second time around. Joanne really put us at ease. I had sort of suspected that the problems that I had the first time were because of the management and I was a lot more sure once I talked to Joanne. She left us feeling as though we were making our own decisions.

The first visit with the midwife is the first encounter that the woman and midwife have together, face to face. While their connection may have begun before the first visit through phone calls, thinking about one another, perhaps even as social acquaintances or friends, this first visit marks a beginning. This is the first time that midwife and woman get together as "my midwife" and "my client."

For the woman, this first visit marks an important point in her decision making process about her pregnancy and birth experience. This is a conscious decision - requiring thoughtfulness, commitment, and perhaps even bravery. Challenging the cultural "norms" of going to a physician for maternity care and planning a hospital birth brings a woman to a different form of responsibility or connection with this experience of pregnancy, birth and parenting. Many of the women I interviewed said that they were not entirely clear initially why they sought a midwife. They were looking for something different from what they had

previously experienced or what they had heard was usually experienced in hospital births. Some had heard about midwives from family or friends, but were not too clear what this might mean for them. Heather was introduced to the idea of midwifery care when her cousin recommended that she see her midwife Ellen. After her first visit, she told her partner "*I felt instantly relaxed with Ellen, and that without her specifically saying so, I felt that the birth would be in my control.*" Other women come to the first visit with a strong sense of what to expect. She may have attended a film night, a VBAC group, or taken a women's health course. She may know that this is a place for questioning, for talking about previous experiences or current expectations, and for being relaxed or being informal. After all, midwifery has been associated with an "alternative" approach to healthcare. Would it not be expected that everything about coming to see a midwife will be different from seeing a physician?

That first step into the phone call, the first appointment may bring many questions. *Is this for me? What can I expect? Will I like this person? How will she treat me?* The first visit with a midwife may bring additional questions. *Is this safe? How will my family and friends react to this choice? Can I afford this? Will I be in trouble with the law or the health care system? How will I know if this is a good choice?* Heather had family support for her decision to go for that first visit with a midwife. Other women have been "warned" about the dangers of having a midwife or having a homebirth before they come for that first visit. Some women have asked long-term family physicians for advice about midwives and have been told that her physician will no longer assume any of her care if the woman sees a midwife. And yet the women still come. It is not an easy decision to make this first step.

Tone: a woman centred approach

The first visit is a meeting of two individuals who have some commitment to work together. This is not a casual meeting where a connection of you and I to become a "we" is unnecessary. The woman comes to the midwife for a particular service and the midwife has particular knowledge and skills that may meet some

of the woman's needs. While the final decision of whether this particular midwife-woman pair is going to "work" may not be made at the first visit, the tone set in that first visit influences both midwife and woman. The possibilities of how "we" may work together are introduced. Will "we" be casual or formal? Will "we" have particular rules in what is appropriate to discuss, to do? Will "we" have a leader and a follower or develop into some form of partnership? How will "we" make decisions?

The invitation

As I observed first visits, I heard the midwives begin by inviting the woman to speak about herself, her experiences, her questions and concerns. Some women are hesitant at first, perhaps expecting that this first visit will be like many of the other first healthcare visits she has experienced in her life. By the time a woman reaches her childbearing experiences, she is an expert in first visits with physicians. She recognizes the sense of anticipation - a blend of anxiety and excitement, of fear and yearning. She is accustomed to the nervousness of sitting in the waiting room, looking at old magazines, trying not to touch the person in the next chair, and listening for her name to be called. She answers the questions about her health and illness history, the details of her menstrual cycle. She removes her clothing and wears a paper gown, stands on a scale and has her weight declared. She knows that a first visit usually includes having a vaginal examination. Her knowledge of these kinds of first visits may lead her to passively participate in the visit, waiting for questions, waiting to be told what to do or what will be done to her.

Perhaps she is hesitant because she is unsure what the midwife wants to hear. Women are accustomed to responding to specific questions. Do you have any allergies? Do you have a history of diabetes? How many hours was your last labour? Her answers fill the blanks on the form, provide a picture that can be compared to the standard of a "normal" obstetrical patient. Being asked an open-ended question: *tell me about yourself*, comes as a surprise. Does this midwife really want to hear about ***me***? Christie expected that Tess would be

interested only in the "medical parts" of her pregnancy. She gave the details of a premature birth, a miscarriage, a recent illness requiring medication. Jane only wanted Paula to turn her baby from the breech (buttocks down) position to vertex (head down). She expected to lie down, have the baby turned and leave. Both were surprised when the midwives encouraged them to speak of themselves. Often we are treated as ***any woman***, not as ourselves. Seyla Benhabib (1987) speaks of two conceptions of self: a generalized self and a concrete self. When we are treated as *any woman* we are a generalized self. We know ourselves only in how we fit with the norms, the standards of a theoretical woman. Our concerns are only the concerns of others if they are clear deviations from those standards. Christie's focus on her "medical parts" clearly fits this experience of being treated as *any woman*. Certainly Tess would need to know about these medical details to come to an understanding of Christie and her pregnancy. Tess wanted to know more.

Even women who come to this first visit with a long list of questions may be operating from an *any woman* perspective. Christie, Laurel, and Cynthia spoke of needing to know the midwife's rates of episiotomy, cesarean section, and induction. Many of the popular books and magazines available to maternity care consumers e.g., *The rights of the pregnant parent* (Elkins, 1985), advise women that the frequency that the practitioner uses various interventions is the measure of a "good" practitioner. Knowing how the practitioner usually treats *any woman* may help to inform the woman that this is an acceptable practitioner for her. For example, if she knows that the rate of cesarean section is 3%, she may find some confidence that she is unlikely to be part of that 3%. However, the woman is also treating the practitioner as *any practitioner*. Rather than coming to know *this midwife*, the midwife may be accepted or rejected based on her conformity with a set of statistical norms.

By inviting the woman to speak of herself, the midwife is opening the possibility for the woman to be a concrete self - ***this woman***. We know ourselves in our "me-ness" (Dillon, 1992). Our experiences, history, identity and

emotions are all of interest to others who recognize us as *this woman* (Benhabib, 1987). For many women, this is a strange experience in healthcare. So often, our experiences of our bodies are pathologized as deviations from the standard male body (Young, 1984). So often our emotions are discounted. This invitation to look again at herself as herself, an invitation to self-respect, sets a particular tone - a wash of colour, a vibrant hum to the ongoing relation between the woman and the midwife. This midwife does want to know about ***me***.

When Jane arrived at Paula's office, Paula spent most of an hour listening and interacting with Jane and David. It was only at the end of the hour, that Jane lay down for Paula to "turn" her baby. When Paula palpated Jane's belly, she discovered that the baby was already in the vertex position. By the time Jane and David got home, they had decided that they should have a homebirth with Paula as their midwife. Perhaps their decision was influenced by the discovery that this baby was in the "right" position. Imagine the excitement, the relief of this news. But Jane intended to continue with her obstetrician's care whether Paula was able to "turn" her baby or not. The news itself would not change Jane's caregiver arrangements. Perhaps through having an opportunity to speak of herself, Jane was able to really participate in this experience. Rather than following the directions of the professional, she experienced the invitation to take part, to be a partner. Peter Ashworth, Ann Longmate and Paul Morrison (1992) suggest that we can only speak of "patient participation" when the care provider is aware of the emotional meaning of the experience for that individual. Merely using the language of participation and partnership without making the commitment to understanding the individual's experience perpetuates a hierarchical relation (Taylor, 1993).

When Cynthia tells us *"she left us feeling as though we were making our own decisions"*, when Heather tells us *"I felt that the birth would be in my control"* we hear a sense of participation. This participation is different than merely consenting or agreeing to the plans of the midwife. While a high level of agreement may appear to indicate a compatible relationship and good

communication skills (Helman, 1985), agreement alone can never tell us about participation (Toombs, 1987). We must consider the social and cultural experiences that may lead us to agree when we don't really want to. We become experts at not rocking the boat, at compromising, especially when the person seeking our agreement is a person with power, knowledge and status. This participation is also different from doing it alone. The word participation, *taking part*, precludes the notion of isolated activity. Experiencing pregnancy and birth as *any woman* is an isolated activity. While there are care providers present, the woman as herself is absent from this experience.

Really hearing

I observed the midwives as they listened, nodded, smiled, asked questions or even added stories while the woman told of herself. Posing the invitation - *tell me about yourself* - alone does not convey the midwife's interest in *this woman*. The midwife must make a commitment to really hear, not only with her ears, but with her head and her heart. Diane Michelfelder (1989) suggests that a responsibility to others puts a demand on our ears to hear not only what is said but also what is not. Really hearing, using our ears comes from interpretive, active listening. Brett suggests that this hearing *"happens organically. I always sit down with a woman for at least an hour and we just talk - about everything. And by the end of the visit, we both know whether it clicks or not."*

Sometimes, the first visit begins with a phone call. Some women want to get detailed information before they are willing to make the first appointment. The challenge of really hearing is even more difficult on the phone. Kathleen speaks of this difficulty:

> *A woman called me over the phone and told me that her doctor told her that she was high risk because she had some infertility and that she was overweight and that she needed to be in the hospital. If she wants care from me, I'll support her wherever she wants to be, but I wanted to try to get rid of that notion that she was so high risk. I talked to her about her risk factors and said that I wouldn't consider those alone as making a woman high risk. But, I realized that our philosophies were kind of clashing and that maybe I shouldn't have come across so strong over the phone. I think it's all part of learning how to talk to people. And*

maybe if I hadn't come on so strong I would have got her as a client, and I think I have lost her as a client.

Imagine Kathleen sitting face to face with this woman listening to her story of her doctor's diagnosis of risk. Perhaps unheard tears would fill her eyes. Perhaps she would move her body in ways that would give Kathleen so much more knowledge of this woman's story. Perhaps this woman is frightened and this is why she is seeking a midwife. Perhaps she has some need to be diagnosed as being at risk, at least for the moment. This "label" of risk may be important to this part of her journey through pregnancy. Perhaps Kathleen would have been more comfortable not speaking at all. Silence between two people can tell us much, can be supportive, and can help bring out more words. The woman on the phone has a name and a story, but is more difficult to identify as *this woman*. Perhaps it is easier to think of her as *any woman*. *Any woman* who is looking for a midwife, *any woman* who has been told that she is high risk.

Really hearing requires that the midwife orients herself toward *this woman*. While each woman comes to that first visit because she is interested in midwifery care, the midwife realizes the uniqueness of the needs and desires of the woman coming for her care. She knows that the woman has taken a big step in coming to this first visit. She knows that this first visit is never a time to be lazy about this orientation; women always have the socially acceptable alternative of medical care and hospital birth, all paid by provincial health insurance. I find first visits to be a tremendous balancing act, giving the woman an opportunity to tell her story: why she is here, what she has experienced in her pregnancy so far, her past pregnancies, and what she might expect from a midwife. I tell about myself, my work, my practice, and what midwives can do. Midwifery is my livelihood, my business. At each first visit, I wonder if this woman will "pick me." Her choice will mean I can feel a little easier about things like paying my rent. And yet, I know that this relationship needs to feel right for the woman, her partner and for me. A "hard sell" approach - *I am the best midwife for you* - never feels right, no matter

how tempting. This is not the first impression that I want to convey - the tone I want to convey.

Orienting to *this woman* requires a flexibility in approach. A woman who is hesitant to tell about herself may gain confidence in speaking about herself as the midwife asks more questions, tells more about herself, or tells stories about her experiences. Perhaps the woman will not be ready to tell about herself at a first visit. After all, we all have had experiences of making ourselves vulnerable by revealing too much, too soon. Being oriented to *this woman* is the first testing of boundaries. The midwife opens a door and invites the woman. The woman will chose whether this is a door that she will enter now or ever. The invitation is only a beginning. Being oriented to *this woman* requires an acknowledgement that there will always be something new to discover and to learn about each other. Telling about ourselves is in itself a process of discovery. With each telling, new understandings are made, perhaps through the interpretations that we use to bring ourselves to consciousness and perhaps through the reactions of the listener. Our knowledge of ourselves is shaped through our experiences in everyday living. The experiences associated with pregnancy and birthing may stimulate reflection, growth and transformation (Bergum, 1989; Rabuzzi, 1994; Rutter, 1994). Orienting to *this woman* requires a recognition that a particular woman has her own unique story which will evolve or even radically change. Perhaps Jane's decision to have a homebirth with a midwife came from a new way of knowing herself brought about through the questions the midwife asked or through the stories the midwife told.

Anne described a range of activities she usually includes in the first visit. Some are highly practical e.g., explaining the fees, describing the prenatal classes, and asking about allergies or medications. Other activities are more personal: laughing and crying with the woman as she tells her story, holding her hand, or exploring an intensely sensitive issue like a horrible birth experience or abuse. While midwives have some items that they feel obliged to attend to in a first visit, the first visit is seldom routine. I recall a midwifery apprentice

expressing frustration that she could never learn how to do a first visit from her supervising midwives because each time they did it differently.

Mutual self reflection

Orienting to *this woman* also calls the midwife to disclose a sense of *this midwife*. Within the context of her midwifery care, the woman cannot gain a sense of her self as herself, as a full person with full participation if the midwife remains an anonymous, generalized *any midwife*. Robin Dillon (1992) tells us that as humans we are embedded in relations with others, that our sense of self is defined in our sense of our relations. An attunement between midwife and woman occurs when both are aware of the other as persons, with an openness to learning about the other (Ashworth, Longmate & Morrison, 1992).

Alice remarked that it was quite amazing that her midwife appeals to so many different women. She had very specific reasons for choosing Margaret. She viewed her as a very down to earth woman who is "alternative" in her approach. Her partner Jordan also highly valued Margaret, but for different reasons. The appeal of one to another often arises because we are able to see a part of ourselves reflected in an other. At this first visit, mutual reflection of self in an other may call to a sense of one-ness, a midwife-woman pair. Interestingly, midwives report that women who elect to interview several midwives before deciding on the midwife who best suits them tend, nearly without exception, to choose the first midwife that they met.

I listened to Gail outline her midwifery background to a woman at her first visit. Her commitment to her work was evident in her description of her struggles to find a way to become a midwife and to gain respect in her community. Tears came to her eyes as she spoke of the equipment that she takes to births. She stopped then and explained to the woman that she had just been at a birth that had been so emotionally moving, that just thinking about it brings on the tears. When the woman asked her if she ever finds birth boring or routine, Gail told her that every birth is a miracle to her. So much information is exchanged in these discussions. For some women, perhaps this is enough knowledge about her

midwife. For others, a curiosity about more of the details is strong. Like the woman, the midwife may decide how much and when to reveal of herself.

At the end of each first visit, Jacqueline shows a video of a birth that she has attended. Clients have donated these videos for her to share with prospective clients. Although Jacqueline concedes that every birth is different, she sees this as an important piece of information for the woman to have in order to make her decision about engaging her care. She says *"it is a nice way of showing how I practice because when I meet someone, I often wonder if they would be how I want at my birth."*

Jacqueline's question - *I wonder if they would be how I want at my birth?* may not be a question asked by all women at their first visit. Perhaps this is an even broader question - *I wonder how this midwife will be with me?* Will she respect me? Will she answer my questions? Will she understand my pain? Will she laugh when I need humour? Will she like me? How the midwife is at the birth, will she be the way the woman wants her to be is just a part of how the midwife and woman come to understand one another, to work together. Women who are not sure of what to expect of a midwife may not ask such a specific question at a first visit. And yet, they may be curious about what a midwife does, what is different, how might this be for me? The video gives information such as the equipment used, who is present, what everyone is wearing (or not), and what is said. It also gives a sense of the approach the midwife takes with the woman.

I recall being at a conference where a series of birth videos were shown. One video stood out for everyone in the audience, even those who had never experienced midwifery care. It showed a waterbirth in a lovely large tub with midwives who were wearing ordinary clothing, not uniforms. But the midwives in this video were directive, hierarchical, focused on their task and not on the woman. The audience commented: *I wouldn't want that for my birth. Were they midwives?* Even when the woman does not know how she might want the midwife to be at her birth, she may recognize when the midwife is acting in a way that she will or will not want at her birth.

Perhaps the other knowledge the woman will gain from watching the video is a glimpse at the relationship that the midwife has with women: women who will trust her judgement in showing their birth video to strangers, women who see this first glimpse at *how my midwife might be at my birth* as important and so will give Jacqueline the video to use that way. Jacqueline tells each woman that she has permission to share the birth video. This conveys another message: that while sharing of videos or stories or experiences may be a part of her practice, it is done thoughtfully, with respect to confidences and to levels of comfort. Jacqueline also shows herself at a time when she is vulnerable, when the midwife has to summon all her resources to be watchful and supportive and see the woman as an individual.

Each woman may describe her midwife in very different ways from other women receiving care from the same midwife. In the research interviews, I heard one midwife described as being very nurturing, technically skilled, and very "alternative." Each description by a different woman who either received primary or back-up care from this midwife. As I reflect on my own practice, I recognize how tempting it is to play a role that I think might appeal to a particular woman. Perhaps she will pick me if only I can take on a "hard sell" approach and be "spiritual" enough, "alternative" enough, or "high tech" enough for her. And yet, I recognize the dangers in doing so. On a practical level, is it possible to remember which role I've chosen to play with each woman? Is it possible to maintain that role under conditions of stress or exhaustion? At a recent first visit it was obvious that the woman was seeking something very spiritual in her birth. She knew that this baby was a daughter. She spoke of wanting to include her mother and her grandmother, of wanting to connect the women in her family through her birthing experience. Her partner however, was very connected to a scientific view of pregnancy. The couple had arguments during the visit. I could choose to play a role, perhaps something "spiritual" for her, or something "scientific" for him. But, in playing a role I assume a stance of *any midwife*. I am

not entering into that relationship as myself, I am entering as a midwife that I believe that one of them expects me to be.

Midwives spoke of a need for honesty in presenting themselves. Brett says *"I'm really honest with women. I let them know that this relationship really needs to work, everybody needs to feel comfortable with it."* Brett, like other midwives, will refer a woman to another midwife if this doesn't feel like a good match. She speaks of times when she has been tempted to agree to provide care to a woman where the match has not been good, thinking that it will work out. *"There ends up being tension. You have to like her, you really do because you are doing something with her that is so intimate that it is going to affect the rest of her life."* Brett does not use a "hard sell" approach to encourage women to pick her as their midwife. If there is any sense of a "hard sell," it is in her belief that this relationship has to be a good match. Not only does the woman have to believe that this is the midwife for her, but the midwife has to believe that she can be the midwife to this woman.

This tone, a woman-centred approach, is not merely about working with women. Being woman centred requires an orientation to *this woman*, an attention to hearing, and an openness to intersubjectivity - becoming "we."

Tone: being "at home"

As Laurel described her decision to use a midwife for her second birth, she spoke of her first visit. *"I knew immediately when I went in for my first visit that I was home."* These words are simple, and yet suggest many things about that visit. Being at home is being in a place that is comfortable, safe, and familiar (Baldursson, 1985).

Laurel may have been referring to the physical environment of Holly's office. Most midwives have some sort of "office" to do their prenatal care. This office may be shared with other care providers, in a storefront, in an office building or in the midwife's home. Some midwives see some or all of their clients in the woman's home. The offices of midwives tend to be a reflection of their work. All have walls covered with photos and art work depicting mothers, babies,

and families. All have collections of books, magazines and videos. All have a toy corner with books, trains, puzzles, or music makers. All have comfortable chairs, perhaps even a couch or two, in the "waiting area." Some have a kitchen or a place to make tea or coffee. What is missing from most midwife offices is the receptionist. The women walk into the office and are usually greeted by the midwife herself. The "examining rooms" usually have chairs, a desk, and a couch or bed. Missing is the gynecological examining table with its noisy paper cover, the metal stirrups and bright lamp.

Coming into this environment is familiar, yet it is not. In most health care situations, the environment is more clinical, not a place that could be called home-like. We are told to sit up on the bed or the table. That high, narrow piece of furniture with a cupboard underneath, paper on top and metal stirrups placed part way down somehow seems neither a bed nor a table. The room may have cupboards and counters holding mysterious bottles, instruments and packages. As the patient, we may wonder which of these will be used with us. Yet, this clinical setting is what we come to expect when walking into a first appointment. The presence of something more familiar, a bed, a chair, a desk may be a comfort, and it may be confusing.

The familiar features of the midwife's office may contribute to feeling at home yet, being at home requires a sense of welcoming. Perhaps that welcome is a sign on the door, a smiling midwife letting the woman in, another obviously pregnant woman pointing the way. *Come in, come in, sit here or here, a cup of tea, a book to read?* This sounds like a *visit* to a friend or relative, not a healthcare *appointment*. The word appointment comes from the Old French phrase *a point* meaning "to a point." An appointment, something fixed by prior arrangement is decisive and business-like (Ayto, 1990). Visit, on the other hand, is derived from the Latin *vidēre*, to see, which descended from the Indo-European *woid-* meaning wise (Ayto, 1990). A visit, going to see, somehow seems less formal, more welcoming than an appointment.

Being at home comes from a sense of safeness, belonging and protection (Bachelard, 1969). Perhaps this is what Laurel meant when she said she was home - it was easy to feel she belonged. This space created by the midwife is like a small oasis where women and families can feel safe to ask their questions about pregnancy and birth, to ask for what they desire or imagine for their experiences, and to be themselves. This is a space where she can act without worrying how others will perceive her. Here, everyone thinks midwifery is a good choice, everyone thinks that homebirth is wonderful, and everyone regards her changing body as beautiful.

In my practice, I notice that some women spend far more time in the office than their "appointed" 30-60 minutes. Some make themselves at home, perhaps sitting to read, chatting with the midwives or other women, or making a snack. Laurel and Alice both spoke of feeling free to stay as long as they wanted, to give their children snacks and cleaning up after themselves. How often are we this comfortable in a home other than our own? Perhaps with a close friend, with our mothers, or with our sisters? I noticed that the midwives, too, are at home in their offices. There is a familiarity and casualness to their words and actions: sitting on the floor to finish a puzzle with a small child, sipping on a cup of tea while listening to a woman tell of her last birth, or expressing excitement during a phone call from a previous client announcing that she is pregnant again.

Being at home together at visits sets a tone that carries through the entire pregnancy and birth. The ordinary-ness of the office space without high-tech equipment, lab coats and receptionists speaks to the beliefs of the midwife and the care she will provide. The necessary items: a doppler, a blood pressure cuff, urine test sticks are there, but in a matter of fact, casual way. Women test their own urine, weigh themselves, and handle the equipment. These are not the magic tools of a professional expert. These are the items of this home. Those who are at home here are welcome to use them. If it is safe to have prenatal care in this ordinary environment, it may be safe to have birth in an ordinary environment as well. Being at home together in the midwife's office opens the

possibility that the midwife and woman will also be at home together in the woman's home for her birth.

Tone: the "illusion" of enough time

Midwives tend to allot at least one hour for a first visit. With few exceptions, the first visit is only talking: the midwife and woman (and often partner) asking questions, telling about themselves, and beginning a sharing of information. Time is needed to give the woman an opportunity to ask her questions, to feel comfortable to ask the important questions, and to tell the important stories.

Many of the women told me that they were very conscious of the midwife's relaxed attitude about the time that the first visit took. Women expressed not only a sense that the midwife was comfortable in giving them the amount of time that they needed for that first visit, but also that they felt comfortable in using the time, without guilt. Laurel had a cesarean section for her first birth. She had moved to a new province between her first and second pregnancies and was looking for a labour advocate for her second birth when she found out about Holly. She said *"I like the amount of time that Holly seemingly has for me, whether she does or not, I don't know. That illusion is always there and I love it."*

The "illusion" of enough time is felt by many women at that first visit. The perception of enough time does not come from allotting one hour or even two or three for that first visit. Often first visits with other care providers are longer visits as well, needing enough time for intake interviews, filling in of paper work, doing that more detailed physical assessment, and allowing time to get blood and urine samples. And yet, even with that extra time, we may leave feeling rushed - not enough time for my questions, to feel comfortable, or to find the courage to say the things that I wanted to say. Van den Berg (1970) suggests that we develop our sense of time, of enough time in our world, through the activities that have meaning for us. A 10 minute visit may drag on if it seems as though there is no reason to be there and we are wasting time. And yet, an hour may seem too short if the questions we wish to ask have been ignored. By inviting the woman

to tell about herself, the midwife brings the context of the visit into the world of the woman. Laurel described her visits as feeling as though *"**my** world is everything to Holly."* Perhaps the "illusion" of enough time is in giving the woman an opportunity to tell her story and for that story to be valued, respected, trusted, and believed. Camille was also amazed at what she was able to accomplish in her first visit with her midwife. In one hour she was able to do what she had been seeking since her first birth, a cesarean, having spent many hours with other care providers. She said *"the first meeting I had with Gwen was the first time that I felt like my first birth experience was important to someone other than me. We began to talk about what had happened and it was the first time that I had joined with somebody and cried lots about the birth."*

The midwife's consciousness of time also influences the "illusion" of enough time. Rather than feeling rushed because she knows that she has four other women booked in the same hour, she has the knowledge that she has a full hour (or more) to spend with **this** woman. But the reality of the midwife's life is that she can always be interrupted at anything she does. She is always aware of the call of the pager, the woman in labour, the woman at home with questions or concerns. The midwife is able to convey a sense that nothing is worrying her, that there is all the time that the woman needs, even when potentially there is not. I remember my first job where I was on-call. I was nervous about committing myself to doing anything during my on-call hours. What if I was called? I would scurry about like an obsessed woman when off-call trying to do all the things I had not done when on-call: my laundry, grocery shopping, hair cuts, and personal time with friends or family. When I became a midwife, I realized that this pattern would not work. I never really had off-call time except when I was on vacation. I could not let laundry accumulate or cupboards go bare. I could not continue telling friends "not tonight, I might have a birth." My way of accomplishing the illusion was to learn to live life as though I am not on-call and then to let go of what I was doing when the pager summons, to shake off the annoyance of leaving 5 loads of wet laundry in the drier as I head out to a

birth out of town. As I approach the woman's home, I re-centre myself toward *this woman*. It is now her time. If I am in a prenatal visit or doing a prenatal class when the pager calls me to a birth, I hope this will give the woman (or couple) that I have to leave behind the confidence that when she really needs me, she will be my priority. I will give her enough time.

Tone: attention to the lived body

Usually the first visit does not involve any physical examination or assessment. Even when a woman comes to a midwife very late in her pregnancy, the physical examination is delayed until the woman has decided that she wants to have this midwife for her care. Because Patricia had a strong sense that she was healthy and that her pregnancy was progressing well she did not seek out any prenatal care until she was nearly 8 months gestation. She did not want to experience her pregnancy as a disease or illness.

The physical examination parts of prenatal care can be exciting: checking on the growth of the baby, hearing the baby's heart beat. Other parts can be intimate and leave the woman feeling vulnerable: the pelvic assessment, pap smear, and breast examinations. Whether exciting or intimate, the way in which attention toward the woman's body is directed may influence how the woman experiences her pregnancy and birth. We are cautioned in our enthusiasm to examine, measure, auscultate, and the other ways of objectifying the woman's body during her pregnancy (Leder, 1984; Young, 1984). The use of language such as *the* cervix, *the* uterus, *the* fetus, the obsession with a pattern of weight gain, and the lack of regard for the woman's need for gentleness are all ways of alienating the woman from her lived body experience of pregnancy and birth. It may seem that objectifying the woman's body (attending to symptoms) is a harmless useful activity. However, in childbearing, the functional processes of growing, birthing and nourishing a new human can easily shift the attention of the woman and others to simply viewing the woman as the body responsible for accomplishing these tasks. Women's pregnant bodies have been metaphorically described in many ways e.g., a hostile vessel, a reproductive machine, and a

showcase (Duden, 1993; Martin, 1987). When our attention to our bodies takes on a sense of body as object, we begin to alter our sense of ourselves. Sally Gadow (1993) suggests that this sense of self as an object occurs as the woman as herself disappears from attention and the functions of the body take precedence. When providers participate in this objectification, they may assume authority and control over the woman's body, or at least the body parts of interest to their specialty. When this happens, the woman may feel that her description of her experience is not valued and it is up the care provider to decide if the body is working correctly and to prescribe treatments if it is not.

Although most midwives do not do a physical examination at the first visit, attention to the lived body experience is a tone set at this visit. In telling about herself at the first visit, the woman tells about her body. Her self report of symptoms such as nausea and vomiting can draw the woman's attention to her body as object (Leder, 1984). Maxine listened as a woman told her that she is experiencing "morning sickness." Rather than limiting her questions and advice to the symptoms themselves, Maxine asked the woman how this is affecting her life: her ability to eat, to sleep, to work, and to be intimate with her partner. The midwife's questions draw the woman's attention back her body as lived. The woman and Maxine together came to understand this particular experience of "morning sickness."

The absence of physical examination also reflects the midwife's belief in the lived body as presented by the woman. Rather than the midwife needing to see for herself that the information the woman gives about herself is correct, the midwife listens to what the woman tells her, perhaps asking questions or clarifying information. This re-centres the information with the woman. This is her body, her experience, her truth, and her knowledge. And yet, there is not a sense that the midwife only asks questions, only listens. Maxine, for example, did discuss many strategies for reducing nausea with the woman, listening to the woman telling her what works, what doesn't, and what appeals. The woman asked Maxine what she thought about various approaches, what worked for her

during her pregnancy. We slip back into objectifying the woman if the midwife does not engage in the discussion with the woman. The woman becomes *any woman*, who should have complete ability and freedom to make and carry out her decisions. The midwife too, becomes *any midwife*, to whom it does not matter what choice the woman makes. Attention to the lived body draws both the woman and the midwife into attention to their particularity, not only as individuals but as a particular "couple" who have decided to come together in this context of midwifery care (Gadow, 1993).

Attention to the lived body experience requires the care provider to acknowledge that the woman's body is part of her wholeness. She cannot assume permission to touch, to examine or to manipulate merely because the woman has presented herself for a first visit. Like the boundaries that we may expect the woman to draw about when and how much to tell about herself, we must also expect that the woman may need to draw boundaries when and how much touch is permitted. Delaying the physical examination until the woman has decided that this is the midwife for me conveys a respect for *this woman*.

This beginning sets a tone for the way the midwife and woman will work together, the woman's body is respected as part of her wholeness, not as a task to be accomplished at the outset of care giving. The midwife and the woman learn together about the whole woman, including the woman's body.

Setting the Tone for Trust, Friendship, Birth Experience and Awakening

Setting the tone for the relationship is a theme in itself. The understanding of being *with woman* is enhanced through this viewing of the experience. The tone, or perhaps tones interwoven, blended, melodically composed, provide a sense of the possibilities for the way that a particular midwife and particular woman may experience being *with woman*. Perhaps the phrase ***setting** the tone* leaves us feeling a contradiction. When we think of *setting*, we tend to view something that is permanent or fixed. Throughout the discussion, there is a strong sense of openness to change, evolvement, and transformation. We might

think that this means there is no tone, that the form of this relation is elusive, so prone to change that no *setting* ever occurs. And yet, the tone, or tones revealed through a discussion of being woman centred, an illusion of enough time, being at home and attention to the lived body convey a setting of an approach.

In this study, the tone, or tones are heard throughout the discussion of the other themes. The setting of possibilities at the beginning of the relation is like stepping into a still pond. The ripples started with that first step cover the entire pond. Watching the ripples from the north, south, east or west sides may give us a slightly different view of the ripples, yet we understand that they are always present regardless of our particular view.

Chapter Four

Trust

Recently I overheard a woman telling her story of an impending surgery. She was comparing her experience with her surgeon to the experience of one of her friends who had a homebirth with a midwife. Her friend told her that all through her pregnancy, and even up until now (the baby is 4 months old), she feels total trust in her midwife. She has come to expect and know that there is honesty, trust and safety in her relationship with her midwife. If things are going wrong, her midwife will tell her and they will come to a decision together as to what they should do. The woman questions her friend's trust, saying that she certainly does not have that with her surgeon even though her surgeon thinks that she should. She wonders if her friend has been tricked into trusting her midwife. In fact, she wonders if her friend has "blind trust" in her midwife.

This story makes me stop to think about the relations of trust between woman and midwife. I recognize the woman in the story as one of my clients. I reflect back on my experience with her and wonder if I "tricked" her. *"Jema, just trust me, I know what I'm doing." "Jema, don't worry, I'll take care of you."* Other women also express a strong trust in their midwife. At a prenatal class, Barb, a "repeat client" tells the group that she trusts her midwife with her life. Midwives, too, talk about the need for trust in midwifery: trust in the birth process, trust in themselves, trust in the woman, and the need for the woman to trust the midwife.

The word **trust** comes from the old Norse, *traust* meaning help, confidence, firmness. Trust shares its origins with the word truth. **Truth** comes from the root *dru* meaning wood or a tree (Ayto, 1990). The sense of firmness in trust and truth, like the tree, is well rooted to the earth, sturdy even under the weight of snow or the force of wind. And yet, there is a sense of being flexible, able to bend to the ground under the weight of the snow. But the danger of cracking is always there. Trust and truth have a vulnerability when the roots are not well planted, when the foundations that have been built are weak, or when

the burdens are too heavy. There is a need to be watchful about our relations of trust, perhaps building in protections like the gardener who wraps burlap around small trees before the first winter's snow or who trims off branches in order to protect the whole tree. When we hear the woman speak of Jema's trust we recognize that this is a deeply rooted aspect of how woman and midwife are together. And yet we hear the question of how this kind of *"total trust,"* this *"I trust her with my life"* could be possible. How is trust experienced between midwife and woman?

Re-Placing Trust

Janet - I'm talking about me here

When I first met Elaine and Tasha, they told me "well of course you should consider a VBAC, women have been having babies for thousands of years." Dr. Barth, who was my obstetrician at the time said something that he considered similar, but I consider markedly different. He said "I have a 80% success rate with VBACs." On one level I suppose that should be a true comfort to me if I am on his caseload, but what if I am in the 20? In my mind I thought, who cares about your success rate? I'm talking about me here. When I told him that I was thinking about having a midwife, he just photocopied my papers and said "I can't be seen as condoning midwifery at this point, find another doctor." I had my son at home with Elaine and Tasha. There were some complications after the birth that meant that I had to be transferred to hospital.

With my next birth, I went to Dr. Dobbin thinking that I might need to have a hospital birth. Unbeknownst to me, he looked at my records and consulted another obstetrician. Then he gave me this story about how my baby was going to burst through my abdominal cavity. I said "I would be very interested to see that literature" and he turned all red and said that he didn't know it off the top of his head. Well of course he doesn't, it doesn't exist. So, I tried to appeal to him on a more emotional level, asking him to understand how important having a VBAC is to me, how outraged I am that I had a needless cesarean in the first place. He told me that the best I could hope for was a healthy baby. So, I switched to Dr. Grey. He also wanted me to have a lot of monitoring and interventions, but was willing to entertain the possibility of VBAC. One day I asked him what would happen if I didn't do all the monitoring and interventions and he said "Janet, you can do whatever you want, but I can't be responsible."

For most of my pregnancy, I continued tandem care with Elaine and Dr. Grey. Sometimes, I would go directly from Elaine's to his office. I had already checked my urine at Elaine's and told the nurse what my urine results had been. The nurse wouldn't accept my report, she just wrote down "no sample." I finally stopped seeing Dr. Grey at about 38 weeks. What finished it was the tour of the hospital. The nurse spent 20 minutes talking about parking, then she rushed us past the operating room saying "and if your obstetrician thinks you should have a cesarean, then that's what has to be done." Then she took us to the nursery where the babies were removed to be checked over by the pediatrician and she said that if the nurses felt that the baby shouldn't be breastfed and needed to be supplemented, then that's what would happen. Then we walked into the delivery area and I looked at the whiteboard in front of the nurses' station with everyone's name and dilation on it and I turned to Stewart and said "I think we'd better go and buy our homebirth supplies."

Trust is the cornerstone of healthcare. When we examine the codes of conduct, the ethical guidelines, and the pledges of healthcare professions, we see trust as a required element of safe and ethical practice. It is difficult to imagine going for surgery or for diagnosis of a frightening set of symptoms without trust. We want to have confidence (Bollnow, 1989,c) that the healthcare provider has the appropriate knowledge and skills required for the particular "job." But, we also want to trust that they have the sensitivity not to hurt us or to make us feel vulnerable, and that they are honest in their work, not subjecting us to unneeded procedures or costs, or not over or under emphasizing the concerns of our particular situations. The intensity of the birthing experience calls particular attention to the need for trust. Chantal says *" Giving birth is a baring experience. You are bringing the midwife into your home, she has to be someone you can trust. Otherwise it makes you uncomfortable."* Some (e.g., Morse, 1991) suggest that there are some healthcare situations that we can enter comfortably without trust. For example, we have many brief interactions within healthcare such as minor treatments and diagnostic tests where a stranger carries out the procedures, may interact pleasantly with us and then we are both on our way. And yet, a need for trust is not absent in those situations. Perhaps we do not know the provider well enough to trust her particularly, but we come with some

sense of trust that the treatment or test is necessary and the correct one for our situation. We come trust that someone knows whether the provider actually can do these minor things. I reflect on my own sense of dis-ease when going to donate blood. After nearly 100 painless donations, I had three consecutive experiences where the nurse was unable to find a vein. After much pain, blood spilling and bruising I was sent home to come back in a month to try again. Now, I look at the nurses suspiciously, I ask them how long they have been working there. My need for trust in this brief encounter has surfaced.

For the most part, trust in healthcare situations is assumed. When we listen to stories such as those of the woman I overheard, we recognize that her surgeon assumed that she would trust him. In a culture where certain people are granted trust, power and status by virtue of their professional qualifications, it is no wonder that this surgeon expected her trust. We recognize the symbols of that assumed trust: the white lab coat, the stethoscope around the neck, the diploma on the wall, and the use of technical language. The recent social questioning of unconditional trust of professional groups or institutions comes as a disturbing surprise to those who have come to expect this trust (Hodgkin, 1996; Sockett, 1996).

Trust has been essential for midwives who work without regulation and within an environment where there is at best, suspicion and at worst, hostility on the part of other healthcare providers. Midwives do not have the benefit of legally sanctioned professional qualifications that sometimes "buy" immediate trust within this culture. Nor do they have malpractice or liability insurance, that can "buy" their way out of trouble when trust has been broken or challenged. Women who seek a midwife's care must find a different kind of trust, not a piece of paper with qualifications, or membership in a professional college in order to be comfortable with their choice.

Re-placing the professional expert

Janet's story speaks to us of the experience within the traditions of healthcare. The professionals are the experts. A hierarchy is established where

the expert is the keeper of knowledge and skill, the patient is the grateful recipient of their care. In some cases, a technocratic influence leads the experts to believe that there is a correct answer or a correct approach (Hodgkin, 1996). We can hear the sense of "my way is correct, anything else is inconsequential" over and over in Janet's story: the doctor who turned her away, the doctor who did not want to hear her emotional concerns, the nurse who would not write down her urine results.

Trust inevitably makes us vulnerable (Code, 1991). When we place our trust in another, we are vulnerable to their access to our lives, to their control, and to their power. Imagine, for a moment, Janet's visits with Dr. Grey. She will be asked about intimate details of her life, perhaps details that she would not share with anyone else. She has already left the care of two obstetricians in the city and realizes that they may have shared their impressions of her situation with Dr. Grey. Janet wants a safe birth, a healthy baby, and some recognition of the painfulness of her previous experiences. She may feel caught in a dilemma of knowing that Dr. Grey may be her best option, but unless she does exactly what he demands, he will no longer assume responsibility for her care. What might that mean? Would he abandon her care in the middle of her labour? In relations where there is an imbalance of power, this vulnerability is particularly evident. Cynthia tells us *"I started with trust in my obstetrician but as soon as I got into the hospital, I just didn't trust him anymore. It was like we were on two different sides. His side was to get me in and get me out and my side was something different."*

Janet's and Cynthia's experiences are not uncommon. For some women, the choice of midwifery came as part of a journey of healing from broken trusts in earlier birth experiences. Recall Camille who went from physician to physician, from therapist to therapist trying to find someone who would acknowledge the pain of her first birth. The experience of trust was dominant in every woman's story, in every midwife's story. And yet, the midwife is also a healthcare professional. Relations between midwife and woman are also imbalanced in

power with the midwife privileged in her knowledge and skills and in the depth of access to intimate details of the woman's life.

Lorraine Code (1991) suggests that women need to learn to trust wisely, being aware of paternalistic control and of relations of power. The tone set by the midwife and woman together opens new possibilities for trust. The lack of familiar symbols of professionalism: no uniforms, no lab coats, no diplomas on the wall calls the woman to find other reasons to trust the midwife. Midwives speak of their constant vigilance in balancing their professional responsibilities with their desire to place the control of this experience with the woman. Rather than acting as the authoritarian keepers of knowledge and control, midwives spread their knowledge to the woman and to the family. Simple acts such as having the woman weigh herself, test her own urine, and carry her own chart show an openness to shake the boundaries between professional and patient. For many women, testing urine is a significant shift. They are surprised at how simple this is to do themselves when it had been such a ritual, a mystery in the doctor's office or the laboratory. Aiden said *" I realized that there was no big mystery to a urine stick and suddenly I was in more control of the experience. Melanie was willing to share that information with me, it wasn't secretive."*

While simple acts may be symbolic of a shaking of professional boundaries, the acts themselves may not be enough to re-place trust. Elizabeth said that one way of showing commitment to shaking the boundaries of privilege and control is to be accountable *"if I say I'll be there at 2 o'clock, then I'll be there at 2 o'clock or I'll call ahead to tell her that something has happened."* Brett tries to answer all questions openly and honestly, acknowledging when she doesn't know the answer. Madeleine explains to women that decisions about hospital transfer from a homebirth will be made by the midwife and the woman together. Through sharing knowledge (the baby's heartbeat) at every prenatal visit and throughout her labour, the woman will know that there is a problem with the baby at the same time as the midwife. *"I feel that at a labour there is no piece of information that I have that the woman does not. The difference at the hospital is*

that they are the holders of information and choose what to give to the patients." Women speak of ways that they recognize that commitment. Chantal took comfort in knowing that Rose was available to her whenever she needed. Patricia, who lived over an hour away from the midwife, knew that Marion would stay with her for however long her early labour lasted. She didn't worry that Marion would say that she wasn't far enough along in her labour for Marion to come or to stay. She didn't worry that Marion wouldn't get to her birth on time. Anne recognizes that women may test her commitment before they invest their trust in her. *"Some women will call early in their care and ask things like 'my other child has an earache, what can I do?' and I'll give her some ideas and I think that when they see that the ideas work, they are ready to trust me."*

Re-placing risk

A well established part of medicalized prenatal care is risk assessment. Each woman's situation is constantly compared with a list of factors "known" to be associated with risks of complications to the woman and/or the baby. In the current system of risk scoring, no woman is without risk in her pregnancy, she is at low, moderate or high risk. In some ways, every woman and every midwife recognizes this risk. I listened as midwives explained the possibility of death or abnormality to women or couples. Maxine told a prenatal class that pregnancy and birth are natural, but as part of nature, there are aspects that cannot always be controlled or predicted, that some babies do die for reasons not understood. But, does the risk scoring system bring about any less danger, any less risk? In fact, there has not yet been a scoring system designed that successfully predicts complications (Enkin, Keirse, Renfrew & Neilson, 1995).

There is however, risk to the woman to see her pregnancy and birth as risks. Looking only at the danger can alienate the woman from her experience and can result in fear and paralysis rather than trust or growth (Smith, S., 1987). Women are frequently told that having a homebirth is a terrible risk, she could have a postpartum hemorrhage. Women are cautioned not to gain too much weight, to avoid activities where falls are possible, to take iron supplements just

in case she becomes anemic. And all this advice is given because of a possible danger, in some cases a rare possibility of danger. Certainly the professional is correct in concern about dangers and complications. I vividly recall my fears at births where I could see the woman's life bleeding onto her bed as I started an intravenous drip and gave oxygen; where it felt as though some massive force was pulling a baby with stuck shoulders back inside as I tried manoeuvre after manoeuvre to help that baby out. Whenever we are "mindful" of an other, we may experience fear when we see a danger facing that other (Smith, S., 1987). Certainly the woman is correct in her need to trust that in these sorts of emergencies where there is true danger, that the professional will be there to protect, to help, and to act in the best way possible.

And yet, living with and facing the risks of life can lead us to new discoveries about ourselves, can deepen our trust in ourselves and in others. Rather than acting as a safe cushion against all possible dangers by assuming full responsibility for decisions about care, rather than paralysing the woman by emphasizing the dangers, the midwife accompanies the woman through this experience of risks associated with pregnancy, birth, and mothering. The midwife is watchful, using her skills to recognize dangers, watching as the woman continues, calling to her when the danger is coming close, preparing her for choices, and staying with her in those choices.

Adele had a long and slow labour. Her blood pressure was slowly rising and she began having meconium staining in her amniotic fluid. At each concern, Alethea explained her worries and outlined Adele's options. Initially, Adele and Tim were reluctant to transfer into hospital, the homebirth was important to them. Adele was afraid that she would not be able to make her own decisions when she was in the hospital. *"Alethea let things unfold and that's what I needed at that point. She advised me what was going on and what I could do. I decided to stay home."* Later, when the signs of distress were even more worrisome, Adele and Tim decided that Alethea's suggestion of going to the hospital for more intense monitoring was their best option. When they arrived at the hospital, the

doctor gave Adele the option of waiting or having a cesarean section. The baby seemed well, but Adele's blood pressure was climbing and her labour progress had been very slow. Adele and Tim elected to wait, but soon there was evidence of fetal distress. *"I felt that I could have the option of asking Alethea to decide for me whether I should have a cesarean now, but I knew that this was a decision that I could make."* Baby Shauna was gravely ill and died several days later. *"Alethea stayed with us all through that experience. She visited us and she cried with us. She kept in touch with us and when I got pregnant again, I never had any second thoughts about having her as my midwife again."* Adele has since had four homebirths with Alethea. Alethea did not abandon Adele when Adele made decisions that were not Alethea's best advice. Nor did she tell Adele that she could not take responsibility for the outcome. Adele had the option of "giving" control to others: to the obstetrician or to Alethea, when the dangers to her and to her baby became intensely evident. But, Adele did what she was afraid she could not do, she trusted herself to make decisions.

Re-placing knowledge

The knowledge, information, and truths that we are accustomed to using in healthcare are often seen as finite, measurable, and replicable truths (Gadow, 1985). The information professionals desire in order to make the diagnosis, and determine a prognosis or a treatment plan is often predetermined. History forms ask for precise information. There is no room for Janet's information about the pain she experienced with her previous births. Camille discovered that all interest in her first birth ended when the professionals discovered that her son was healthy. And yet, women are expected to trust the professional without believing they have provided a full picture of themselves. Isn't this gap in knowledge as serious as neglecting to ask about allergies or current medication use? On the whole, the sharing of information is believed to be unidirectional, from the knowledgeable professional to the patient, perhaps doled out as a form of treatment (Gadow, 1985). Knowledge or information becomes a commodity,

owned by the professional, perhaps desired by the patient. Knowledge is a tool to establish or maintain relations of power, not relations of trust.

Sally Gadow (1985) suggests that the knowledge relevant to healthcare "encompass[es] subjective as well as objective realities, idiosyncratic as well as statistical tendencies, emotional as well as intellectual responses" (p.38). Women comment on their midwife's interest in more than objective facts about their health. They also recognize that their midwives gather knowledge in many ways. Patricia said *"Marion knows me from what she observes about me with my children. And when I'm in labour, she picks up on the little things that are important for that birthing process to happen. Although it doesn't look as though Marion is taking note, she has very keen observation."* Perhaps Patricia's awareness of Marion's observations brings a new level of trust that she need not be responsible for saying everything, the midwife may know about her in other ways. Midwives worry about making assumptions based on their observations, perhaps wondering whether it is ever possible to really know about another's experience unless they tell us about it (Munhall, 1993). Madeleine said that she listens on many levels, both what is said, and what is not said. She realizes that she often must ask some very direct questions to understand. She gave an example of a woman with whom she felt a struggle in gaining trust. The woman's diet mainly consisted of "junk food," she smoked heavily and her blood pressure was becoming high. With each visit, Madeleine felt they are growing further apart until she stopped asking the questions about diet and smoking and started asking about the woman's feelings about this baby and this pregnancy. These questions opened windows to emotional storms for this woman. It was through these emotional storms that she and Madeleine discovered their trust in one another, a trust that was ultimately essential at the birth. *"I had called two different midwives to come as backup for the birth, but neither could make it. I realized that this woman had a 100% trust in me and so I recognized that we could work together to get this baby out. She gave birth in a squat and I reached*

down and handed her the baby. After that we had bonded so deeply because of this incredible transformation we had gone through together."

Many women and midwives suggest that intuition is essential to a midwife's way of knowing about a woman, knowing about what is going on. Robbie Davis-Floyd and Elizabeth Davis (in press) suggest that midwives consider intuition to be authoritative knowledge. Authoritative knowledge is that upon which decisions are made and actions are taken. In healthcare, authoritative knowledge is generally limited to objective or even technical knowledge (i.e. only machines and monitors give us adequately accurate information). Intuition is a connection of physical, emotional, intellectual and psychic understandings where knowing comes about from the use of more than rational processes. Sometimes midwives puzzle about their intuitions, wondering where they have come from, where they are taking them. Perri said *"I get a sense of something pending and I know I should be doing something. Sometimes the outcome isn't what I expect, for example doing a hospital transfer and having a fine birth there, but I think that if my intuition is to go to hospital, then maybe that is where she is supposed to be."* Perri and others suspect that intuition develops over time, that the midwife needs to feel some confidence in her knowledge and skills as a midwife to be open to intuition. The call of intuition is subtle, difficult to hear when concentrating on learning to measure a blood pressure or suture a laceration.

Re-placing knowledge requires acknowledgement that there is always a level of uncertainty in our understandings. It may seem that the strongest, deepest trust comes when we sense that there is certainty: If we know the answer or the outcome, we can readily enter into the experience without fear. Uncertainty may lead us to fear the experience or even to avoid or escape the experience. Doubt comes from the Latin *dubitāre,* to waver or be uncertain. The Old French word for doubt - *doter* or *duter* - has a sense of fear as one of its meanings (Ayto, 1990). As fear, doubt is an "opposite" to trust. Doubt questions the confidence, the firmness of trust. Perhaps the fear associated with doubt

comes from a shaking of a technocratic perspective where certainty is desired. When we doubt, we are uncertain of which possibility is "correct." We want to believe that we can never have two truths. And so, we polarize the possibilities, one desired, one negative: yes, no; right, wrong; healthy, sick. In pregnancy, our inability to have certain knowledge that the newborn will be healthy may lead us to assume that the worst will happen. We fear that the processes of pregnancy and birth will harm the baby.

And yet, viewing doubt as uncertainty may build trust. Perhaps the very act of wavering between possibilities creates a place for many new possibilities. Moving back and forth between possibilities calls us to question our assumptions about certain knowledge. Is this right? Is that right? Or perhaps neither? Or both? So often I hear midwives respond to questions with *"it depends..."* The midwife tells the women that there is not a clear answer to her question, there is no certainty. Would trust really be required if there was certainty? The deepest trust, "total trust" does not come with certainty. Trust comes through venturing through the possibilities, testing that woman and midwife are still able to stay together when certainty is not assured. Janet's trust in Elaine and her final choice to have another homebirth came not from a trust in a certain outcome, but from a trust that Elaine stayed with her, through her complications, through her changes in physicians, and through her choice to have a hospital birth. By opening the possibility that there may be many "right" answers diminishes the fear that unless there is clear evidence of the one "right" condition, then the "wrong" condition must exist. For the pregnant woman, living with uncertainty may bring her to trust herself, her body, and her baby even when she cannot "know" that everything will turn out perfectly. Uncertainty re-places knowledge and trust away from an external standard or truth and toward self: to the woman, to the midwife, to the woman-midwife, to the couple or family.

Uncertainty challenges our notion of what is true (Maturana & Varela, 1988). In living with uncertainty, we must acknowledge a possibility of co-existing truths. In healthcare, truth telling - *veracity* - is a unquestionable virtue. Lies are

abhorrent, intolerable (Sockett, 1996). And yet, this is not a simple matter of finding a single correct answer and fully disclosing it. Even in situations where there is a sense that there is a single, certain answer, we may be challenged in our sense of truth. For example, when the midwife assesses the dilation of the woman's cervix, she ought to be able to say how many centimetres the opening is. Surely this is a scientific measurement, an absolute truth. And yet, for midwives, this is a difficult area for truth-telling[1]. In one of my jobs as a case-room nurse, the unit had a policy that a woman needed to be frequently examined and if her dilation was not progressing according to a normative curve (O'Driscoll, Foley, & MacDonald, 1984), her labour should be augmented. And once her cervix was found to be fully dilated (10 cm), she was to be coached to push whether she felt an urge or not. And once pushing, she could have one hour before other interventions, usually forceps or vacuum extraction delivery, occurred. What a dilemma! How do I tell the truth about the dilation of the woman's cervix and remain somehow truthful to the woman and her own pace of labouring in her birthing experience? Remembering how trust and truth are intertwined brings even more urgency to this dilemma. A lack of regard for truthfulness may threaten trust. And so, the midwife may avoid doing cervical assessments, perhaps only when requested by the woman. It is interesting that one of the hallmarks of a really good birth is one where no internal exams were done, where the woman laboured at her own pace and the midwife used other signs to assess progress. The midwife may reframe the information that she gets from doing the examination. Kathleen tries to be positive about the examination results. *"I reinforce to women that the result doesn't always mean she is going to be another 8 hours. It could also be another half hour. Some women do go from 2 centimetres to 8 in a couple of contractions."*

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[1]A lively discussion of truth telling related to cervical assessment occurred on a midwifery Internet discussion group. Many found this to be a difficult dilemma in their practice. Many experienced personal conflict, valuing informed choice, abhorring paternalism, and yet questioning whether this seemingly "scientific" measure can give a certain answer.

Re-placing knowledge sometimes calls for a "leap of faith." We may ask ourselves or others to trust in or believe in something that they had previously never considered. Acknowledging co-existing truths, valuing subjective knowledge, or seeking knowledge from sources other than the scientific textbooks challenge the boundaries of what we may consider to be acceptable knowledge and acceptable actions. Claire decided to eat her placenta[2] after she had asked Pat for some advice about postpartum depression. Pat gave her a number of possible approaches and referred her to other women who had some experience with postpartum depression. *"I was preparing my placenta and I said to Michael, 'this is either going to work or Pat is having a great laugh on us right now.' When Pat first described it, it was a push for me. I thought it was a joke. I thought I would be squeamish about eating it, but in the end, I wasn't at all."* A leap of faith requires trust. In situations like deciding to consume the placenta, confidence in the knowledge that the placenta may help with postpartum depression may not be enough. This information is difficult to find and confirm. Yet many women who have done this attest to its effectiveness. "If we have another baby I swear that the pot will be heating on the stove, lying in wait for that placenta!" (Molnar, 1996, p.32). The leap takes us to a place we have never experienced before. Sometimes we need someone to closely accompany us to this place. Other times, like Claire's preparation and consumption of her placenta, we are ready to do it knowing our trust is strong enough.

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[2]Placentaphagia, eating the placenta, is common among most mammals. This practice among humans is a well kept secret. It is difficult to find textbook or research-based information, yet the practice is well known among Canadian midwives. The rationale for eating the placenta as a treatment for or a prevention of postpartum depression is that it contains high levels of iron which replenishes that which was lost at the birth and thus re-energizes the woman. It also contains high levels of hormones which may positively affect the woman's emotional state (Molnar, 1996). The preparation Claire refers to is based on a Chinese medicine recipe. The placenta is first steamed, then dried, then crushed into a powder. The powder is put into capsules. The woman takes several capsules each day. Some women do eat their placenta as a meal, perhaps prepared as a paté or stew (van Oploo, 1996).

Trusting in the Body - Trusting with the Body

Much of our knowledge of who, when and how much to trust comes to us through our bodies. Perhaps this is not surprising, after all, to really trust requires more than rational deliberation. Trust is deeply embedded in our sense of self; its consequences vibrate every aspect of our being.

Blind Trust

Jema's friend wondered if she had blind trust in her midwife? The term blind trust is interesting. We might think this is not trust at all, rather, entering into a situation with no thought of trust, no vision of our selves and our world. Perhaps Jema's friend thought that Jema was thoughtless in her trust, that she was not aware of the dangers of trusting so much, so deeply; that she was foolish to place her trust in someone who is a midwife. Perhaps she worried that Jema was being treated paternalistically, that her midwife somehow believed that Jema was unable to make decisions on her own. Healthcare providers justify their paternalism as a form of beneficence, doing good (Beauchamps & Childress, 1989). A midwife could justify paternalism as a way of decreasing stress for the pregnant or birthing woman for adrenaline from too much stress may interfere with fetal growth or with labour (Enkin, Keirse, Renfrew & Neilson, 1995). A midwife may not even worry about justification, she could believe that it is her role as a professional to take on the responsibilities, the decision making, and the authority.

Perhaps all trust, to some extent, is blind. Can we really see all the consequences and all the dangers? Would trust even be necessary if we could? Patricia delayed seeing any care provider until late in her pregnancy precisely because she did not want to be treated paternalistically. *"I didn't want to be told what to do, I didn't want anyone to* ***make*** *me do anything."* Her trust was anything but blind. Her choice to see Marion was based on her understanding of Marion's practice and experience. Patricia had read a lot during her pregnancy and had a sense that she was healthy. And yet she also had questions for Marion. She asked Marion's advice about diet and vitamin supplements. In the

end, Patricia weighed the information and made her own decisions. *"I never did take a multivitamin. I started taking iron after the second visit when I got a blood test that suggested that my hemoglobin was low."*

Some might suggest that this wide open eyed questioning and seeking of knowledge or understanding is a lack of trust. If Janet trusted Dr. Grey, why would she ask him what would happen if she didn't have the monitoring and interventions? Shouldn't she trust his judgement and expertise? Yet open questions seem to be a large part of trust and trusting. I observed midwives in prenatal visits asking *"do you have any questions today?"* and often if there was no question, the midwife raises one herself. *"Some women wonder whether they should have an ultrasound, have you thought about whether you want one?"* Elizabeth says that encouraging questions, being open with answers helps with trust. She believes that the women trust that they can ask the hard questions and not get an angry or dismissive response from her. Keeping our eyes open, asking the questions, challenging the answers allows us to close our eyes when we need to and step blindly, trusting blindly. Our experiences with blind trust help us, perhaps like the visually challenged, to develop other ways of trusting.

Perhaps it is the sense of hearing that brings a level of comfort with blind trust. The commitment to really hear (Michelfelder, 1989) opens the possibility of hearing the call to trust. Often my decisions come from hearing something in the tone of the woman's voice, something in the words she has used and not used. Perhaps the woman is saying that she is fine, she can manage on her own for a little longer, but there is a waver, a vibration in her voice. Women also connect to that call for trust. Anne was at a birth where there was shoulder dystocia. She needed to try a different manoeuvre. *"I said, 'you've got to move right now' and she was over, PLUNK! And she knew from the tone in my voice that she had to move quickly."* With Alice's second homebirth, the baby's heartbeat dropped when she was pushing. *"I heard Margaret say 'this baby needs to come out now.' And I didn't really want to push because it is so painful, but when I heard*

the tone in her voice that something might be the matter, I pushed with all my strength. She didn't tell me to push, I heard it in her voice."

Gut instincts

Trust in the woman's body to safely grow, birth and nourish a child is one of the basic principles upon which midwifery is based. Many midwives recognize coming to that trust is an important part of their journey into midwifery. I recall the sometimes painful shedding of beliefs and values about the need for technology, the need for medical expertise, and the need for institutional resources that I experienced in becoming a midwife. Anne entered midwifery with "*a deep, gut knowledge of half of the population, a really deep trust in the way we are and the way we're built and the way we're meant to give birth."* She sees her work in midwifery as a responsibility to encourage others to gain that trust as well. The midwife's trust in the woman's body informs her practice and her relations with women. Women like Christie recognize that trust during their experiences with the midwife. *"During my birth I felt just totally supported and totally like I was trusted, my body was trusted in what it was supposed to do."*

This deeply embedded trust in the woman's body opens a possibility for other forms of body trust. Midwives speak of trusting subtle body signs. I recall going to a labour where things were moving slowly. At dinner time, the student midwife and I joined the family at the kitchen table to feast on barbequed ribs. At one point I asked the woman if she wanted to try the tub now. The student midwife looked at me and asked why I suggested that, the woman wasn't really even in labour. I told her that the woman had been having hard contractions every two minutes for the past half hour. What did I see? A slight shift in her breathing, a slowing of chewing, a pink tinge to her cheeks. Midwives invite women to trust those subtle body signs as well. Brett attended a birth where there was thick meconium in the amniotic fluid. She and her partner both felt that this woman should go into hospital. But the woman said to them *"I just feel that my baby is ok, let's just stay here, please trust me."* And the baby was fine.

Midwives also trust the subtle messages of their own bodies. Often these messages call the midwife to look a little more closely at what is happening, to wonder if something is going wrong when on the surface all appears to be well. Anne gets itching on her nose, Madeleine and Elise get diarrhea. Elise explained *"we both had diarrhea at a waterfall hemorrhage, we had a shoulder dystocia where we had diarrhea, and we both had headaches at the labour of a woman who was transferred to hospital for an emergency section."* Other midwives notice that they are more likely to be bleeding with their menstrual periods during labours, or to bleed more heavily. Trusting the body calls the midwife to attend to these body cues, to sort out if they are related to fears and anxieties about themselves or about the situation, the woman, or the baby.

This embodied trust cannot be assumed. The midwife must maintain vigilance. Is the statement "I just feel that everything is going to be fine" coming from a knowledge about the situation or a desire for everything to work out well? Does the woman say that she knows her baby is going to be alright, not because she is convinced of that, but because she is frightened of going to the hospital? I recall a student who recognized that her sense at every birth that everything was fine actually came from her terror that something might go wrong and that she would be called upon to do something she could not do. Maintaining trust in our bodies requires that we take the pulse of that trust regularly, checking in with ourselves, with others, and with the situation at hand. Elizabeth recognized that a woman who was seeing her partner was not comfortable when Elizabeth was present. *"When I did her blood pressure, she nearly folded like a scared rabbit."* Rather than assuming an understanding of the significance of this subtle body sign, Elizabeth invited the woman to talk about it. Madeleine's partner called her to come to a birth for a woman in early labour. Her partner was feeling all sorts of her own body cues that something was going wrong; she wanted Madeleine to come to see if she felt it too. Madeleine arrived and immediately felt that everything was fine. *"I don't know what kind of trip my partner was on, maybe she passed three ambulances on the way to the birth. I think that it was her*

intensity that the woman was picking up on and reflecting that anxiety back to my partner." Midwives use a number of rituals and exercises to stay calm, to check themselves. Whether doing yoga, deep breathing, taking power naps or a little meditation in the bathroom, the need to keep a check on trusting is constant.

Mutual Trust

Midwives need to have a deeply imbedded trust in themselves, in the pregnancy and birthing process and in the women to have confidence in providing care and to feel safe. Unlike a hierarchical model where trust is generally unidirectional (Gadow, 1984), midwifery trust is mutual. The woman trusts the midwife and the midwife trusts the woman and they both trust themselves.

Aiden - Shared Decision Making

> *With my daughter Kate's birth, I was 8 centimetres when my waters broke and there was meconium and we went "hmm, you know, let's look at this stuff." And my midwife Melanie had a look at it and went "hmm..." and we trusted her ability to judge whether this would mean a transfer. But she said to us "well this could be problematic, but we'll listen to the baby's heart, unless there are other factors that come up, this in itself isn't going to mean a transfer, unless you feel that you want to transfer." And at that point, we still said "we want a homebirth." I think that there was that choice for us if we wanted to transfer. We had read a little bit and knew that this was not an issue. And so with regular monitoring, she listened to Kate's heart, and it seemed to be fine, so it felt good to stay at home.*
>
> *After the birth, I hemorrhaged and after 2 injections of oxytocin Melanie said "well, Aiden and John, two injections are sort of what I feel comfortable with. I don't know if you know the guidelines, I could offer a third, but this is my comfort level. How do you feel about where we should go from here?" At that point, I thought that it was acceptable for us to transfer. We accepted her comfort level and we went into hospital.*

The woman trusts the midwife because the midwife trusts the woman. A small dose of trust potentially creates a synergy of trusting relations; trust begets trust. It may not be possible, or even important, to identify the source of that initial small dose of trust. Does it start with the woman trusting in the midwife to

even come for the first visit, or make the first phone call? Does it start with the midwife inviting the woman to tell about herself, thus projecting a trust in the woman? Trust becomes both motivator and goal in how the midwife and woman are together. Balance in trust comes from a mindfulness of the interests of an other. Mindfulness need not require an equal attention to the other in the situations of caregiving. The woman needs not provide the same amount or level of care to the midwife as the midwife provides to her. The mindfulness calls to acknowledging the human-ness, the uniqueness of both midwife and woman. Melanie was mindful of Aiden: her wishes to have a homebirth, her wishes to have a safe experience, her trust in herself, and her trust in her midwife. Aiden was mindful of Melanie: her expertise, her level of comfort with complications, her trust in herself, and her trust in Aiden. Mutual trust comes through a balancing of self-love and benevolence (Tomm, 1995).

Without mutual trust, all trust is jeopardized. Imagine a situation where the midwife does not trust the woman, and yet expects that the woman will trust her. How could the midwife carry out her work if she would not or could not trust the woman to tell her about her body or her emotions? Imagine the fear a midwife would experience at a birth if she could not trust that the woman would hear the tone in her voice when she says *"your baby wants to come out **now**."* Perhaps she would not even say this if she could not trust that the woman will be able to "defy nature" and push a distressed baby out in one mighty push. A midwife who does not trust the woman may regard the woman as a hostile environment for her fetus. She would be unable to trust the relationship the mother has with her child. She would not be able to hear the woman say *"I know that my baby is fine."*

A Christian nativity story tells of trusting the birthing woman. When Mary's labour begins, Joseph seeks out the local midwives, Salome and Zelomy to assist Mary. They assure Joseph that they are very skilled. At the birth, Salome doubts Mary's virginity, and through this doubt, loses the use of her hand. *" My false mistrust has brought mischief. My hand's power is now all torn, stiff as a*

stick and cannot bend." (Happé, 1975, p. 240). When Zelomy assures Salome that there is a rightness to trusting Mary, Salome's hand is restored. While the events of this particular birth are certainly a rare miracle, Salome's experience reminds us of the importance of mutual trust. A midwife's hand is essential. Her hand touches, measures, comforts, and mends and yet, if she cannot trust, her hand is useless.

A recognition of the power that trust or lack of trust has in aiding or hindering their work brings midwives to be highly attentive to mutual trust. Mutual trust cannot be assumed. Merely stating that a midwife adheres to a philosophy of trusting the woman does not ensure that this trust actually occurs. Mutual trust requires a constant examination and questioning of our experiences, our relations, and our motives. Kathleen, for example, reflects intensely on each transfer to hospital situation. Did she open herself enough to trust this particular woman? Did her own fears influence the way that she discussed the situation with the woman? Did she perceive realistically just how much trust this woman had in her? Is it possible that this woman will come back later and say, *"this was your fault?"* Madeleine found herself questioning her assumptions about mutual trust with one woman who had a very long labour but did not want to go to hospital. After 52 hours, she agreed to be transferred and had an epidural and forceps delivery. The next day, she told Madeleine *"I was way too tired to be making decisions about staying home."* Mutual trust requires a constant clarification of what this means to both.

Patience

Patience, as an aspect of trust, takes on particular importance for the midwife and the woman. It sometimes feels as though I spend my whole life waiting. Waiting for due dates, waiting for my pager, waiting for labour, waiting for birth, waiting for the placenta, waiting for a rooting baby to latch on to her mother's breast. The women, too, are waiting, anticipating the birth with a mixture of excitement and fear. Patience is a trust of time, process, self and others.

In some ways, a midwife's patience is like the craftsperson, using skills needed for this particular job. At the birth, the midwife's patience in watchfully waiting for the emergence of the baby, sitting on her hands rather than intervening, using warm compresses, changes in position and combinations of pushing and breathing may help the woman feel in control of her birth, and help to reduce tearing of her perineum.

In some ways, a midwife's patience is like the gardener. At each prenatal visit, she marks the growth of the baby, viewing just how well this particular baby "crop" is doing by how closely the growth matches the graph. She knows that human babies take about 40 weeks to gestate and that eventually, all women will go into labour and birth their babies one way or another.

But, neither of these forms of patience remind us that pregnancy and birth are more than physiological events. Pregnancy and birth are about women and their families. The craftsperson patience could be seen as merely a form of procedure, following a set of "rules" about how to "do" a birth. As a gardener, the midwife could view the woman's body as a machine, that does its work according to a preordained pattern. As wonderful as birth is, the ending of pregnancy, the actual birth of the baby is not the only aspect of pregnancy that requires patience. Women, in particular, and their families undergo a transformation during pregnancy and birth. The power of creation, of curiosity in knowing this baby, of seeing herself as mother to this child are all forms of growing or becoming. With patience, the midwife learns to recognize these aspects of transformation in each woman. Patience keeps a midwife from rushing through the woman's pregnancy and birth, merely marking time and not seeing the subtle changes. Part of a midwife's work is to assist the woman to create an environment where she can achieve her transformation.

Patience becomes a kind of waiting that values the woman as an individual. Otto Bollnow (1989,b) says that patience reconciles human being with time, bringing the person into harmony with the course of time. Although time in pregnancy and birth seems fairly stable, the actual experience of time varies from

woman to woman. For some women, 40 weeks is too long, perhaps because of discomfort in being pregnant, perhaps in anticipation of actually having and holding that baby. For others, it is too short. Pregnancy may be a cherished experience, or birth may be frightening, and coming too soon. Patience requires a midwife to recognize these temporal dimensions and join with the woman in her rhythm and sense of time. She needs this understanding in order to know how to most appropriately respond to the woman who asks *"when?"* As I reflect on several of my recent births, I realize just how differently women experience the time of pregnancy, birth, and mothering. One woman began to push her baby out only one hour after she felt her first contraction. With each push, she spoke to her baby *"hurry up and get out, this is taking too long!"* Another wandered in and out of labour for several days and then slowly progressed to be ready to push. With her first push, the baby's head was visible. She told me *"this is happening too fast, I am not ready. I don't like this feeling."* She lay down on her bed and went to sleep for 2 hours before I suggested that it was time to let this baby out. Another woman jokes with me that she will make me a t-shirt with the word *"soon"* on it. She tells me that midwives are true existentialists, the word soon takes on a new meaning every time it comes out of our mouths.

A midwife's patience during pregnancy helps to build trust that she will also be patient during birth, the most critical time for patience for a woman. Through the medicalization of birth, time has become intertwined with trust. Routine ultrasound has become required to establish the woman's due date because she cannot be "trusted" to know her likely date of conception. Labour induction seven days post due date has become standard practice because the woman cannot be "trusted" to continue to safely grow her baby after that time. Active management of labour is commonly used to speed up a woman's labour once she has demonstrated that she cannot be "trusted" to follow along a mathematically developed curve of acceptable labour progress.

Kathleen - Appropriate patience

> *At my last birth, the woman had basically five hours of active labour. Two of that was pushing. And the first hour of pushing, I didn't want to interfere very much basically because it was her first baby and I think that being with a woman means she finds her own power at her birth and I don't exert my power. So I didn't want to interfere too much with her position or being out of the tub because she was in the tub. I maybe suggested a few positions but it was up to her whether she chose to do it or not. It was only into the last half hour of the second hour of pushing that I really got interventive. And I always really look back to ask if it was appropriate? Did I do the right thing? And for this woman, I think the intervention at that last half hour was appropriate because the baby's heart rate went down and I didn't feel comfortable with that so I got more assertive about getting the mom to push strongly and coaching the pushing more.*

Is impatience ever appropriate for a midwife? Can patience result in negligent or dangerous care? As long as mother and baby are well, there really are no time limits. However, waiting must be watchful. Waiting becomes indifference, if a midwife does not pay attention to progress, growth, and transformation. Kathleen may have waited longer for this woman to push on her own cues, but this may have resulted in harm to the baby. A midwife's impatience, or unwillingness to wait may take the form of concern for the wellbeing of the woman, her baby, her family. Rather than simply allowing problems to occur, a midwife must acknowledge and face them to truly be patient with the woman as an individual. Patience is not a form of trust if it does not consider the interests of the other.

Patience has a powerful reciprocal nature. A woman's impatience may alert the midwife. Yet the midwife needs to be mindful of becoming caught into this hastened rhythm, to remind herself of this woman's experience, her goals and expectations, and to carefully look for the source of impatience. Likewise, the midwife recognizes that her patience can mediate the woman's rhythms. Patience can have a calming, soothing effect that returns peacefulness to a situation that is spinning out of control. Madeleine saw that her role was to bring

her patience to the birthing situation that made her partner anxious. Her patience served to calm the intensity that had built.

Patience also requires that both midwife and woman are patient with the building of trust. Although trust can be found instantly, a deep trust may take time to evolve. Perri first met Hope on Hope's due date. This was her fourth pregnancy and she had just come to the decision that she wanted a midwife. Perri agreed to be her midwife, but recognized that her trust came from a general trust in women's ability to give birth. *"Of course, she was having her fourth baby, I felt I didn't really need to know her that well."* Anne worries about having enough time for trust when the woman comes to her very late in pregnancy. So often, it is those women who have many issues about their pregnancy, their past births, and their relations with professional caregivers to resolve. There may not be enough time for the woman to build trust with her midwife. Although Aiden moved to a city with several midwives during her second pregnancy, she chose to return to the community where she had her first birth and use the same midwife. She recognized the work that she expended in finding the trust and did not want to start that kind of work part way through this pregnancy. Yet, time itself is not the critical element in gaining trust. Although Patricia and Jane did not begin seeing their midwives until the end of their pregnancies, they immediately recognized the trust that their midwives had in them and the trust that they could extend to their midwives.

Coming back the concern of Jema's friend, is the trust between a midwife and woman dangerous? Is it blind? When we view this trust through the lens of hierarchical healthcare, where relations of power are assumed and not acknowledged, we rightly see this "total trust" as a potential danger. The vulnerabilities of the woman are many. The opportunities for the professional to use power to control or annihilate the other are numerous (Whitbeck, 1989). And yet, viewing this trust through the tone set for the midwifery relation suggests other possibilities. This "total trust" takes on both fragility and strength. The mindfulness of the interests of the other allows for strength and points to the

fragilities. We recognize that "total trust" is, at times, necessarily blind. We also recognize that in that blindness, there are many other ways of finding, feeling and extending trust: through words, tone, touch, and bodies. Trust itself is perhaps a goal of midwife and woman. Their activities together are oriented to reaching this goal. Trust is also a motivator or facilitator in how a particular midwife-woman pair will be together. The trust perceived by each, by both together, may influence all other aspects of their relation.

Chapter Five

Having a Birth Experience

Chantal - I loved my birth

> *You know, it is such an enlightenment to have a baby. Even if it was long, I would go through something ten times worse. At the end, the pain is nothing. I loved my birth. It was long and it was painful. But I loved it. I think it's a gift - it's really a blessing to be able to go through that process. I really wish it to anybody. I really didn't want to go to the hospital. I didn't even fill out an application. The midwives have a form to fill out all the admitting information and I thought "no, I'm not going, I'm not going." But after 30 hours, it was just a different perspective and I went. And at the hospital it was nice, the work my midwife did there was nice. She came with me and she supported me and that was really important for me. It was painless. We went to the emergency and zip we went right up to the room and I could lay down and I got injected and that was that. When I watch the video of my birth, it is like somebody who has never seen and you give them their eyes back. Before I got pregnant, I didn't know that I could love that much. I'm looking at Sylvie today and I'm thinking I loved her so much the minute she came out, the way she smelled, it was messy, yet it felt so good. It is a blessing - the best thing that can happen to me. It's like the best day of my life. I can close my eyes and see it again. It was so intense, it is always in the corner of my head, I remember how it was. And that feels really really good.*

Since becoming a midwife, I have been struck by the difference in the birth stories told by women who have midwifery attended births and by women who have not. I recall the number of times that I attended a gathering of women who began talking about their births. Each woman seemed to outdo the others with horror stories of her birth(s). I was always amazed at the number of women who believed that they "almost died" giving birth, when I had seen so few women "near death" in all the years of working in tertiary obstetrics. The birth stories of my childhood, of my early years as a nurse were mostly these kinds of stories. Stories of fear, of pain, of secrecy. When I first found the midwifery circles, I began to hear a different kind of birth story - a story full of triumph, of celebration, even when things didn't go quite right. Stories like Chantal's do not seem to be

about achieving a goal or a "perfection." The stories take on an urgency: needing telling, beautiful and moving, each a story of strength and joy. The stories don't become stale with telling, the excitement of the birth is re-sparked with every telling of the story. The emotions, laughter and tears, stimulated by the women's birth stories, vary and come easily.

When I arrived at Heather's home she had photos from her two births set out on the kitchen table for me to look at. I watched her excitement and pride as she turned page after page of beautiful photos of her in labour, giving birth and celebrating her new child. Other women showed me part of the videos taken during their births. Another pointed out a picture on her bedroom wall that she used as a focal point during one of her births. Some women pointed out the actual place of their birth - the bed, the tub, the kitchen floor. Meg pointed out the picnic table in the backyard that she had built during her labour and Alice told about her decision to videotape her last birth. She said *"I wanted to see every intricate detail of the birth. I find it wonderful. Some women ask me 'how can you video tape that?' But to me it's beautiful. After the baby was born, I watched it right away."*

Midwives too, told me birth stories. Their stories were about births they had attended and about their own births. What is it about the birth experience that brings women to tell the story again and again?

Claire - What I got was a birth experience

> *It was exciting and reassuring to be in labour. In early labour, Michael and I went for a walk. When we came home I called my midwife Pat and told her "ya, I think it's happening now." She came over. It was so nice to see her, even though I wasn't in really hard labour yet. She just fit in so smoothly. I'm normally Ms. Frazzle before a big event, but that day, I was calm. We moved the furniture and set up the swimming pool. I noticed that Pat sat quietly and observed. I could tell that she knew where I was at.*
>
> *During my labour Pat and Michael and I would have conversations which I could take part in and fade out as the contractions were becoming more intense. It's so nice to be hearing someone's voice that I trusted and being able to talk about much more in-depth things. The*

encouragement was there, the right words were there. Pat said something about giving in to the power and I don't know if that was something she says to everyone, but for me it was the right thing. It really helped me to then focus on that, on the power of it. And release some of that fear. To me, it was, "don't be afraid!"

I remember that the labour hurt. It was so intense, I thought, I can't have these contractions on top of each other, this is too intense. I think I can see why people go out of their body if they have just been in a car crash. There is a need to get out because it is too much, you just can't do it. My labour obviously wasn't too much because I stayed in. I have glimpses of being in the tub and feeling an incredible pressure and feeling the whoosh, it was like someone turning on a firehose between my legs when my water broke. I said "something broke!" It was a very definite feeling. I didn't have a really strong urge to push, but it was as though my body was already pushing. Pat never examined me at all, she just knew that I was ready. The first time she saw my vagina at all was when my daughter was coming out. The head is the hardest part. I think it was only one contraction from when her head was born to when the rest of her was born, but it felt like a very long time. I was on my hands and knees in the pool. Pat caught her and then she passed her through my legs so the other midwife could pass the baby to me. And at the end, the physical part of the relief is so amazing! In my photos, it looks like I'm saying "I can't believe I did this!"

Afterwards, I just felt so cared for. The midwives were so tender. I felt so comfortable - being bathed, being fed, hearing the midwives in my kitchen. I was lying on the couch in the living room. Pat brought the placenta to show to all of us. The two grandmas were there then. It was a really neat female thing to know about another end of the birth process. It's the way it should be.

When I look back on the birth now, it seems too incredible. How did a person get inside me in the first place? I look at her now - the other day I had her lying across my knees and I thought, "ok, you're 11 pounds now, I can't believe you were inside!" I was watching her move and remembered what it felt like on the inside. When I see it, it is like a physical remembrance. Sometimes when she smiles and grins, I wish to take that little remembrance and have it with me completely, but I'm going to start to cry because it's painful to remember and not remember. You want to hold onto those moments but they are gone.

I wish that there were a way to mark it better because it's such a profound experience. A person is appearing who has not been here before in this form. I thought about it afterward and decided that the

marking was just that it was done here and that the experience itself was marking every little thing, seeing the placenta, my son's excitement at his new little sister, having my parents here right after the birth, and sharing pizza with my family and the midwives afterwards. Those were all very special moments. The first few days after the birth were a phase that I'll always treasure. It was just like a little cocoon around our house. It was just like the baby just dropped into our lives but also like she was just always there. It felt seamless. I came looking for a safe birth and one where I would feel more comfortable and what I got was a birth experience.

What is this "birth experience" that Claire tells of in her story? Is not every birth an experience, a birth experience? And yet, from Claire's words we understand that this experience is not just any birth experience. There is something about this second birth that has captured her attention in a way much different than her first. Other women and midwives nod when they hear stories like Claire's. We seem to recognize this "birth experience."

As a midwife, I recognize that some births capture me in a very intense way. I recall telling a friend that I had just returned from a very nice birth. She then asked me what made a nice birth? Good question. In a way, they are all "nice." Every birth is special, unique, a miracle. I feel such privilege to be included in this special moment in the life of each woman, of each family. But there are definitely some that are "NICE BIRTHS." They aren't necessarily fast or easy or uncomplicated. When I reflect on these births, I recognize that others at the birth, the midwife, the partner, the children, the friends also have a "birth experience."

Jenny's was a "nice birth" - long and painful. And yet, a seventeen year old having a homebirth - the joy on her face when that baby was born - her almost smug look when she checked to see that he was a boy and told everyone that this was Toby, just as she knew all along.

Mia's was a "nice birth" - so peaceful in a swimming pool in her living room with quiet music playing in the background. It was one of those April days when you realize that winter really is going to end. The sun shining through the living

room windows, through the transparent walls of her pool, cast a magical light around her. Her laughter when she felt her water break will stay with me forever.

Theresa's was a "nice birth" - I've known her for many years. When I left her following her birth, quietly nursing her baby, both of them cuddled up in Tony's arms, I felt my heart swell with something like pride in her personal journey from the young student I knew years ago to this confident mother.

Miriam's was a "nice birth" - Miriam was my first primary client who actually had a homebirth. She had planned a hospital birth all along, but changed her mind when I got to her home. Her labour progressed much faster than she anticipated. Her husband Richard was so worried about her and held her tightly while she pushed on the birthing stool. When Timothy was born, he was tangled up in his cord, wrapped three times around his neck and then once around each leg. This birth was special because Miriam was a first - special because she trusted me in the end - giving me more confidence in myself.

Libby's birth was a "nice birth" - but long long long and hard. I listened to her tell me that she thought she would die and I worried that I might misread her cues, that she had enough. But each time we checked in with one another, she insisted that she was doing ok, she could stay home longer and could manage the pain. Her baby was posterior and took hours of hard pushing to come out. More than six months later, she still seems to be walking a little above the ground. She did it!

Pauline's was a "nice birth" - Pauline kept me wondering right through her pregnancy. In some ways, she was not someone that I would expect would even contemplate a homebirth. I worried sometimes that she only heard her friend's story about her wonderful homebirth and never heard any of the story about what labour is all about. I worried sometimes that she would be totally unprepared for the pain and exhaustion. She called me at three in the morning and said that she had been in early labour since three the morning before. She had wanted to wait until morning to wake me, but was finding it too hard to wait any longer. I could hear the pain and worry in her voice and assured her that I was leaving right

away. When I got there, she was leaning on her kitchen counter. Her husband David was sleeping and her mom and dad who were going to be at the birth were still at home. We stayed in the kitchen for about an hour drinking grape juice. I rubbed her back constantly. David still slept - she felt sorry for him and wanted him to get his rest. After an hour in the tub, where she went to relieve her shaky legs, she started to make pushing sounds. I listened for a while and decided it might be time to check her. Her cervix was 8 cm dilated. I phoned my backup midwife and her mom and dad and hauled all my equipment up to the bathroom. When her pushing started to sound more serious, David finally got up to see what was happening. Not long after everyone had gathered in the bathroom, Pauline said that she felt something break. With the next contraction the baby's head was visible. She still couldn't believe that she would be having her baby that morning. I held her hand and placed it over the baby's head and said to push a little. Suddenly, it was like a jolt of energy. She smiled and looked at everyone in the room and told them that she was going to do it soon. In a couple more contractions, the baby's head was crowning - all the while with his mother's hand on his head. She slowly eased him out and pulled him up to her tummy.

Whether it is the "birth experience" described by women like Claire, or the "nice births" described by midwives, it is clear that the birth experience is important to both midwives and women. Midwives speak of birth as being a time of growth and transformation - for women and families and for themselves. Kathleen described some of the value of the "birth experience:" *"I had a wonderful homebirth that made me feel so empowered. That is what I bring to my care with women, to help them find their power in birth, as a birthing mother and a woman. I think that having a good start with the birth is so critical with parenting. Birth is one of the most fantastic times to help her find her power."* Perri said *"I think I grow with every birth. It's like adding something - I learn from each one. And I think that women can grow through their births to become a more mature person, a more wholesome parent."*

Birth at home - at home with birth

Perhaps the possibility of a "birth experience" such as that described by Claire and others is connected to the woman's choice to have a homebirth. All of the women in this study planned homebirth for at least one of their births. Some had previous hospital births. Others chose home for their first births. Some chose home as a way to heal from earlier birth experiences - ones where they were left angry, frightened, crushed. Others heard about homebirth from friends or family and found that the idea appealed to them. Some felt that this choice was a tiny rebellion against the norms of this society's healthcare system. Others wanted particular experiences that could not be accommodated in hospital such as waterbirths or having their children present or having their partner catch their baby. Not all of the women stayed home for their births. Chantal, Camille and Jane were transferred to hospital during their labours. Aiden and Laurel were transferred after their births. And yet, all speak strongly and positively of their homebirth experiences. Camille who had a repeat cesarean section after attempting a VBAC (vaginal birth after cesarean) at home speaks of having two births: the first was at home where she wanted to be and where she gave birth to **herself**, and the second was in hospital where she had the cesarean section to birth her son.

Midwives also speak of the uniqueness of the homebirth experience. Throughout time, midwifery and homebirth have been closely linked (Barrington, 1985; Tyson, 1991). In Canada, with the exception of midwives in fully regulated practice (e.g., in Ontario), the only way that midwives have been able to be the primary care provider for women is when the woman chooses homebirth. And, with few exceptions, the only way that women have been able to choose homebirth is to engage the services of a midwife. However, midwives claim that the link is at a deeper level than the practical limitations of choices surrounding homebirth and midwives. Homebirth reflects the very essence of midwifery: birth is a normal healthy experience which can safely occur at home; the woman is at the centre of the experience - she is the host; family is important and can be

involved in any way that works for the particular family; birth is a spiritual experience - a fragile and subtle aspect of birthing that is often lost in the routines of medicalized care.

Both women and midwives face opposition for the choice of homebirth. Jane said *"My mother refused to talk to me. She was absolutely against homebirth. She said that I was taking my baby's life in my own hands and that I had no right to do this."* Whether from other health providers, family, friends or casual contacts, the warnings about the dangers, the risks, the foolishness of this choice continue to be dominant in North American society (Davis-Floyd, 1992; Kitzinger, 1991). Despite evidence supporting the safeness of homebirth (e.g., Tew, 1995; Wagner, 1996), home is often seen as a dangerous place for birth and the hospital is usually considered the appropriate place for birth. In some jurisdictions, physicians are prohibited from attending homebirths, risking loss of license if they elect to do so (Barrington, 1985). For women who regard birth as an illness, fraught with potential dangers, it is not surprising that they choose to leave home to go to a strange place in order to give birth with all the "experts" in attendance. However, for women who regard pregnancy and birth as a normal, healthy state that blends relationships with physiology, the hospital seems a strange place for birth. Megan noted that although she liked both her physician and the hospital setting where three of her babies were born, she found that going to the hospital left her disappointed in her birth experiences and was disruptive for her family. For her, the homebirth experience was a social event involving her whole family.

When we think about home, many images come to mind. Often we note the physical structures: the appearance, the rooms, the furniture, or the decor of the house. When that house is my particular home, I have a familiarity with the physical structures. These come to me like an old friend. I can spot the roof of my parent's house long before I can see the house - that sighting stirs memories of comfort, laughter and good meals. Is it the physical structures that make the homebirth experience unique? Is it perhaps being able to give birth on a bed

rather than a narrow delivery table? Is it perhaps being able to sit in the tub or stand in the shower during labour, rather than lying in the labour bed? Is it perhaps being able to look at pleasantly painted walls with wallpaper boarders and attractive paintings, rather than staring at blank walls of institutional green? Is it perhaps being able to curl up with baby after the birth in a comfortable rocker or recliner, rather than being transported by wheelchair or stretcher to the postpartum unit?

When we move to or build a new home, we organize our belongings in a way that creates meaning for us (Bollnow, 1961). This organization creates space, a space to sleep, to eat, or to relax. The order of our world is based on familiar things being in familiar places. Although birth may be an unfamiliar experience, the connection to a familiar world brings the peacefulness of the home to the birth. Women know the comfortable places in their homes from previous experiences with illness, fatigue or nesting. The bed has her place, where the mattress is moulded so that her body fits. The chairs and sofas are all tested for the best position, the ones that the pregnant woman can get in and out of easily, the ones where another person can sit near to rub her back or speak softly. The tub is her own, no need to worry about who sat there last, was the tub cleaned, will there be hot water? The best places of the house are known: a place for privacy, a place for comfort, a place to accommodate others.

In recent years, most Canadian hospitals have added home-like touches to their maternity departments. Birthing rooms have beds with wooden headboards, reclining chairs, rockers, televisions or stereos, showers or tubs, wallpaper and art. Rather than having separate rooms for labouring and birthing, most hospitals now have birthing rooms. Some even have LDRP rooms (labour, delivery, recovery and postpartum) so that the woman stays in the same physical space from admission until discharge. Do these additions result in home-like births? Vangie Bergum (1989) notes that the hospital labour and delivery areas appear more like hotel rooms than someone's home. Hotel and hospital were originally synonyms, meaning places where guests were received (Ayto, 1990).

In the hospital, the woman giving birth is the guest; at home, she is the host. In fact, the home-like touches may contribute to a feeling of alienation or strangeness. These rooms are more like someone's idea of what home is like, but too sterile, uncluttered, too bland to be a particular person's home. I was once asked if I wouldn't be more comfortable providing care in a hospital where I was sure that there was running water, lights that work, furniture, and tidiness. I think of births where I've had to find my way through piles of dirty laundry or children's toys, where I've had to dodge the dog that seems to always want to be under-foot, or where I've boiled pot after pot of water so there will be enough for a warm bath for mother and baby. These seem minor inconveniences. Recently, I attended a birth for a family who live in a tiny out-building on a farm. There was no running water, no telephone. The space itself was barely big enough to contain the couch that became the family bed at night, the table and chairs, refrigerator and storage shelves for food, toys and clothing. I could not imagine that family feeling at home in a hospital birthing room.

Even if the hospital has all the physical items of the home, none of these are known to the woman. For example, the bed has been laid on by thousands of women before her, none long enough to make her mark. The space is created by the arrangement of furniture and other objects in the hospital with no meaning for the labouring woman. Although the uses of many of these things are familiar to the woman, they are not organized by her. The bed is positioned in the room for the convenience of the care providers. The comfortable chairs are often positioned so that they are out of the way of the working areas. At home, the woman does not need to use her labouring energy to get to know the space and the furnishings.

Meg - Home as a familiar birthplace

> *My homebirth was great. With my first birth, I had an induction in hospital. I had no idea what normal labour was like. This time, I woke up at 7 in the morning and got up to the bathroom and I had show and thought, "mmm maybe I'm in labour." And I waited until the contractions were 7-8 minutes apart and phoned my midwife Astrid. I had an appointment with her that morning. She said "don't come in, just stay*

home." By noon the contractions were about 5 minutes apart. It was so neat, because they had been 7 to 8 minutes apart and then all of a sudden they went to 5 minutes. It was as though my body knew what it was doing and it was so different from the first one. I phoned Astrid again. She asked "do I have time to have lunch?" and I said "fine" and she said that she would come right then if I wanted her to. She came around 1:30 in the afternoon.

I kept doing things. I made the bed and pulled the food out to have afterwards and baked a cheesecake. It was great. My daughter, Noel changed her clothes about three times - she couldn't quite get the right thing to wear. Astrid came in and checked the baby's heartbeat and it was really relaxed. We sat and talked. My partner, Brad started to get anxious and started to build a picnic table. Later, Astrid started to read a book and I went outside and watered some flowers and then I took Brad's hammer away from him and helped build the picnic table. By then the contractions were about 3 minutes apart so I hammered some nails and put the hammer down when the contraction came and walked around the house and then picked up the hammer again. It was just so relaxed. I came in and told Astrid that the contractions were 3 minutes apart and there were some that were lasting 3 minutes without a break and I thought she should check to see what was happening. I found out I was 8 centimetres. She called her backup, Joan, but she didn't arrive until after the birth. I called Brad out the window to come inside and he hammered the last nail. I went to put the baby's laundry away and I had a really bad contraction. I guess I must have made some noise that I didn't realize because when I went to get Astrid, she was already there. We just went into the bedroom and I had another contraction, leaned over the bed and Astrid rubbed my back, then my water broke. Astrid turned around to get something and I must have been making some grunting noise because she asked if I was pushing and I said "I don't know..." and the baby's head was just about there. So she started hollering for Brad. We tried to get Noel to get him and asked her "please knock on the door and get daddy out of the shower or he'll miss the baby." And she started asking "why, why, why???" Astrid and I started yelling as loud as we could to get him to hear over the shower.

We managed to shuffle over to the birthing stool. It felt much easier than lying on my back. I remember from the first prenatal class, somebody in the class was from a farm and talked about animals - large animals like cows giving birth and what good noises they make and they're deep strong noises. After five minutes of just making little squealing little things, I finally found the mooing thing. Brad says it sounded more like a grunt than a moo. It felt like a moo.

It was just so peaceful. It was nice having just Astrid and Brad. It was so quiet and so fast I couldn't believe it. I had a lovely nightgown to wear for giving birth and I never even put it on. And Astrid was so calm all the time. I can't believe anyone can be so calm with something that happens that fast. She wasn't pushy. She didn't tell me "push now" or " this is how you should breath." It was nice that way. It felt like it went the way it should have gone.

After the birth, everybody stayed for 4 hours. It is really nice to have everybody there to join you. The postpartum visits afterwards were great. The first time I was in the hospital for 4 or 5 days and people were there, but it just felt as though you should know all of it and everybody is just so busy in the hospital and they don't have a lot of time to just sit down and talk. This time it was nice - any tiny little concern, I could just ask Astrid. We had a lot of support. We didn't have any family or friends close by. Some people complain they can't get any peace and quiet because they have so many visitors. It was almost the opposite for us. We felt kind of isolated. So it was nice to have somebody to come by who would do nothing but talk about the baby and me. It was nice to have somebody to phone if you did have a problem.

Having a baby at home feels in one way a kind of pampering. There's just a time when you don't really want to be travelling. Especially me, I'm an hour away from the hospital. It is nice that everyone is in your house. It's a sense of community - inviting people into your home.

Perhaps the familiarity of the home opens the possibilities of what the woman can do to get through her labour. Meg used building a picnic table to distract herself between contractions. Imagine the satisfying feeling of pounding nails with an intensity that matches the strength of the contractions. During her contractions she paced through the house. This is her house, she need not wonder whether she can venture down a hall or enter through a doorway. She can reach out to the walls for support without looking - after all, she has walked these routes time and time again, perhaps in her midnight trips to the bathroom, perhaps when rocking Noel to sleep.

Chantal - A bank of memories

Having my birth at home gives me a bank of memories of things to think about. Like every time I go into that rocking chair, that is where I had my first part of my labour - the time when I could still sit. And that is very nice. Being at home really also helped me to control the stress. I

knew where I could lay down. And I knew what corner of my house was really comfy. I knew what CD I wanted to listen to. I knew that everything that I may want was there because it is my own home, so I had it there. And that was really really reassuring. It provided me with a security blanket. I think it put me in control of my birth and helped me to be strong about it. So, even if it might have been a little bit harder because I couldn't have drugs, my home was like my drug. It gave me a natural means of helping myself through it. And that is really really comforting. My home was like my pacifier for my birth.

The familiarity of home may provide the woman with a seamless experience. Home before and after the birth in one way remains the same - and yet, a very important event occurred there. The use of her things in her space not only provides comfort, but gives a new meaning to the space and contents of home. Her birth experience was lived and is remembered as a part of her everyday world.

Is there something beyond the familiar contents and structures of home that makes a "birth experience" possible? Otto Bollnow (1961) describes home as the centre point of a person's world or lived space. At home, the person is rooted to the world in a space that is safe, protected and familiar. The walls of the house separate the person from the outer, strange and potentially dangerous world. At one hospital, all births which occurred in the labour room were called "homebirths." Can a homebirth occur in the hospital? The hospital may be the centre of the world of the physician or nurse working there, but it is part of the outer, strange world for the woman. Some women find the world of the hospital to be frightening or confusing. Camille described arriving at the hospital after she, her partner Terry and her midwives decided that a hospital transfer was necessary because her labour had stopped progressing.

Camille - An alien world

My first encounter with the hospital was the guy who came out to the car with a wheelchair. I am in the car in the middle of a huge contraction and he is pulling on my arm trying to get me out of the van, and I'm saying "bud, I can't move right now, you'll have to wait until this is gone." And then he said something like "gee, you're cutting it really close" and I thought to myself "it's not close at all, I'm not going into the

hospital to have this baby in two seconds, you have no idea." He just thought he was trying to help me into the hospital. It wasn't anything against this guy, it was that I was going into this alien world where people don't know what I need and they are not going to be watching me and noticing the way I need. They know nothing about who I am, what I want, what I'm giving up. Then I remembered the woman from admitting rushing me up the hall to the birthing room and I thought "we don't need to rush, what is the hurry?"

Camille further describes her hospital experience:

I'm laying in this bed, all wired up. I didn't want that. I wasn't happy with the nurse. I hated the intern or whatever he was who started to fill out this stupid little form and tells me in the middle of this that I have a heart murmur. I thought "I don't need to know right now that I have a heart murmur. I don't need to know right now that my body is not working." I wanted more confidence, but they made me feel like I know nothing, I own nothing, this is not about me any more - it is about people who are going to assess me and do to me.

And so finally it came to the decision to have another cesarean section. It felt ok to make the decision with Terry there and the midwives there - we were all together. It was really awful between making the decision and waiting to have the surgery. I remember being in increasing pain and pushing and pushing because my body just made me do it and the nurses just kind of walked around and did their thing. Here they are the same people who were rushing up the hall thinking that I was going to have this baby in a second, and now all of a sudden they couldn't be bothered with me because they realized I wasn't going to push the baby out. I felt so horribly abandoned. My midwives kept telling me that I was doing fine. They kept loving me and touching me and they were there for me even though the baby wasn't going to come out that way. They were the only ones who didn't abandon me. When they finally took me to the operating room, the midwives told me "this is where you're going and we'll wait right outside because they won't let us go in with you." It was really comforting to know that they were there. But the thing I didn't expect was the feeling in the operating room. The contractions by that time were so huge again and the anesthestist was fooling around with all this stuff and there was all this scurrying around. I wanted to be awake to see my baby born but the epidural wasn't working and the anesthetist didn't want to do it over, so I had to have a general. The anesthetist admitted that she hadn't done a lot of epidurals and so I didn't want her practising on me. So I was unconscious and alone. Terry wasn't there, my midwives weren't there. It was like I had gone into this alien world and they separated us out and I did what they needed me to do.

When I woke up, a man I had never seen before was holding this newborn baby about 5 feet away from me and he wouldn't let me touch him or hold him. He just held him up and said "you've had a boy, I'm just going to put him in the nursery where we are going to check him over and as soon as you get to your room, I'm going to bring him down." And they didn't bring him down for hours. So I had this baby that I hadn't held and I was angry because he had lied. It felt like more separation and more like this doesn't belong to me.

The hospital where Camille had her cesarean section has birthing rooms with all the home-like features. And yet, she did not feel at home there. When the woman steps into the strange world of the hospital, she may find she is helpless in her attempts to keep from being caught up in the activities of that world, rather than following her plan that was made in her world. The midwife too, may be limited in her ability to assist the woman to follow her plans once in hospital. The hospital is not her world either. While the woman is generally "welcomed" into the world of the hospital, the midwife may be viewed with suspicion and merely tolerated as part of the woman's "birthing plan." The midwife may be caught in a dilemma of feeling very uncomfortable in the hospital environment, yet feeling the responsibility of providing support to the woman and family. I find hospital births to be among my most difficult experiences as a midwife. The woman has hired me to be a support, an advocate in this environment. And yet, I often feel invisible there. Or sometimes, far too visible. My presence may give the woman a label as a trouble maker, a radical. Like many midwives, I started my healthcare career in this environment. I can translate the looks and comments. Another midwife, Rachel, described her need to find a balance when in hospital: *"I get a tension in my gut. It comes from the environment. It's not necessarily what they are doing, it is just something that I'm aware of and I have to try to breath that away so I can be calm for the woman I am supporting."* And yet, recall Chantal's story. She was so sure she would have a homebirth, she did not make any preparations for going to the hospital. And yet, she also speaks of her birth in a way that we understand that she was at home with her birth.

Home as a safe birthplace

Home is generally thought of as a safe haven, a place to go to be protected, to be safe from strangers (Baldursson, 1985). Women choosing homebirth weigh the risks and benefits of home and set their own limits to what would be considered a safe homebirth experience. Doubtless, there are women who would never consider home to be a safe birthplace and would never choose homebirth. When home is not a safe place, when the woman perceives danger there through abuse, lack of privacy, or conflict, home is not likely to be perceived as a safe birthplace. For some, the perception of safeness is present, yet, home is not the comfortable, familiar place where the woman can be at ease during her birth. Teresa had some strong negative feelings about her home related to earlier conflicts with her partner Drew who reminded her that it was his house, not hers. Although a safe place for birth, Theresa believes some of her earlier feelings about the house negatively affected her birth experience. The woman's perception of home as safe is an important part of the experience. As Jane said, *"It felt, and this is going to sound really stupid, but it felt like the house was hugging me almost. It seemed to take on an almost human quality of protection and security."*

A mother wishes to protect and safeguard her child. A woman who perceives danger in her birth place may have as much difficulty giving birth as a woman who perceives danger in her neighbourhood has difficulty allowing her child to venture out into that world. In making her decisions about her birthplace, a woman confronts and conquers the safeness issue. Most women get information about potential complications, perinatal statistics, midwives' knowledge and skills from reading, talking to their midwives, prenatal classes and from peer support.

As the woman makes preparations for her homebirth, she creates her home as a birthplace before the actual birth experience. The preparations she makes go beyond the nesting rituals of putting up the crib or decorating the baby's room. She sees and touches the supplies and equipment that the midwife

will bring with her and makes plans for where these things may go in her home at the time of birth. When the midwife comes for a home visit, the woman shows her where she may give birth, perhaps asking for advise. "How should I protect my carpets?" "Will the midwives have enough space if I decide I want to give birth in this room?" "How can I be sure I will have enough hot water?" The woman shops for supplies for the birth, such as a plastic cover for her bed, olive oil, and "K-Y" jelly and in this shopping, she recognizes the impact of homebirth. Lea said *"When I was buying my birthing supplies, I was going through the grocery store so proud of what I was doing and I wanted people to ask me questions so I could just tell them that I am having a homebirth."*

The woman performs preparatory acts for the birth itself such as getting the bed ready, selecting towels and linens, deciding whether she wants to buy a swimming pool, finding the "right" pan for the placenta, and deciding what is to be done with the placenta following the birth. Her deliberative activity in preparing the tools of birth is perhaps one step in giving her body the right environment for birth. She is shaping the space of her home by putting things in their proper place, preparing the home to be a birthplace. The sheets and towels selected are usually old, well known ones, unlike the hospital where a disposable paper drape is used.

> *I got off the bed and stripped the four-poster down, bringing the birthing sheets from the hall closet. The rubber sheet we'd used when Anna was born in this room went over the mattress first, then a Turkish towel, and then the linen, washed clean but stained. Tobie had used these same sheets when Sam came, in this bed with its carved finials. Before Anna's birth I'd welcomed this sense of history and looked forward to sharing my journey into motherhood with her... I stacked a half-dozen clean towels on the dresser. The room was ready. (Sexton, 1988, p.23)*

For some women, the arrival of the midwife and her equipment can create some disturbance in this order. Up until that time, everything in the home is part of the home. Although the midwife is a welcomed guest, anytime a new person

and new things enter our home, it is necessary to rearrange the space. For some women, that rearrangement may temporarily disrupt labour.

Patricia - Disrupting the flow

> *At first, when I'm actually in labour, having people come into the house is disruptive. I know that when I'm in labour and everything is progressing, the first disruption is when Brent goes to call the midwife. Then I'm ok for a while, but as time goes by, I start to feel a bit of a tension building because I'm expecting the arrival of the midwives. And then once they get there, there is a little bit of tension because it's usually the middle of the night or extremely early in the morning. And that usually disrupts my labour - even stops it. I think it is just a disruption when you are kind of in a flow and then somebody comes in and there is a sudden flurry of activity. I'm a very private person and sometimes I just like to be by myself or with Brent in the bedroom. Things progress a little better when I'm by myself. So, the midwives just go sit in the living room or the kitchen until I'm ready for them.*

The experience of the midwives in providing care in the home makes the midwife a comfortable guest. Most midwives do at least one home visit prior to the birth to familiarize themselves with the woman's home and to give the woman an experience of having the midwife in her home prior to the birth. Kathleen tells women that she comes to their home as a guest who will try to help the woman and family to have the experience that they want. She wonders if her comfort in working in the woman's home comes as a surprise to women. *"I sometimes wonder if they are thinking 'hey, Kathleen is going through my cupboards.' After the birth we clean up, do laundry, dishes, straighten up. We do it because we want to make it easier for the family after the birth and because it is part of the complete package that I tidy up after myself."* She also worries about the message she could be giving in doing this tidying. *"I was at a birth where the woman was transferred to hospital. I was the midwife left behind to straighten things out and I did it really well. But I wondered if I would be sending a message to the woman that I think she's a lousy housekeeper because it was pretty obvious just how much cleaning up I had done."*

Midwives are comfortable being in women's homes and women are comfortable having the midwife in their home. When the midwife comes for the

first home visit, some women feel a need to be completely tidy and organized. But by the end of the postpartum visits, most women feel comfortable being themselves when the midwife comes to their home. She knows that the midwife will not judge her if being herself on a particular day means that the kids' toys are still all over the floor, or that yesterday's dishes are still in the sink, or that she is still wearing her nightgown at three in the afternoon. Jane says that she feels she can be at home with her midwife in a way similar to being with her partner. She doesn't have to worry about having her legs shaved, or if the door is open while she is going to the bathroom, or if her blood drips on the floor.

In addition to the preparations of equipment, women spend time selecting the place of birth. As opposed to hospital where the choice of place is generally limited to the bed in the birthing or delivery room, the woman has many choices at home. Some women prefer to use their bed in their bedroom. They say that giving birth in the place where they conceived completes the cycle - both intimate acts occur in the same place. Megan, Heather and Claire wanted to give birth in water, but knew their bathrooms were not big enough. The birthing pool (a children's wading pool) sat in readiness for weeks before the birth. Because the "place of birth" sat around the house, it became a familiar, safe place for the other children to be included.

Some women like to maintain contact with the outside world particularly during early labour. Claire went for a walk in the early part of her labour. Diane described how she like being in the sunshiny living room for part of her labour, but once her labour became more intense, she wanted to go into the bedroom where it was darker, more like a nest. During labour women change their plans about the actual place of birth. Lea initially planned a romantic setting in her living room with dim lights and candles, then moved to the bathroom then to the bedroom. She said *" I hate this bathroom, I can't have it in here. Forget it, it's the grossest room of my whole house."* I find that I am often following women around their homes during the last part of labour, carrying the essential supplies for the birth from the bedroom, to the bathroom, to the living room, and to the

kitchen. Women often find a small secure place when they finally settle down to birth. I often joke with women who at prenatal homevisits show me their spacious bedrooms and ask if I think we'll have enough space. I say that there is lots of space there, but we're just as likely to end up all jammed in the space between the sink and the bathtub. And often we do.

At home, women give birth in a place that is used for everyday activities. During the beginning of strong labour, Molly sat on her living room floor folding diapers until the whole basketful was folded and then went to her bedroom. Meg built a picnic table. The sense ordinariness, of familiarity in the space for birth need not make the experience any less special to the woman. After all, many special events and celebrations occur in one's home. Seeing the familiar walls, treasures and furniture can be reassuring when everything inside her body is undergoing change.

Whose birth is this?

By using her own things in her own space, the woman is taking ownership over her birth. Could Claire speak of having a "birth experience" because she felt that this was *her* birth - hers to tell about, to enjoy, and to savour. This re-placing of the centre of control to the woman is different from a consumerism approach *"she can do whatever she wants"* (Gadow, 1980). It is different from the control of routine driven care *"we always monitor the baby for 20 minutes."* It is different from subtle coercion *"do this for your baby, do this to be a good girl."* Some may be concerned that by leaving the "control" in the hands of the woman, the baby will be at risk. But, does "my birth" have to imply that this is only about the mother, her experience, her needs? It is fascinating to watch Anne Waddell in the National Film Board's *Born at Home* (1993). Anne is clearly in control and has ownership of her birth. And yet, she is constantly reminded of the needs of her children, and of her partner Steve. She remembers to ask Steve if he wants to catch the baby and stops to tell the children that she is going to hurt a little bit - all just seconds before she pushes out her third child. Ownership of birth includes other important people as well as the mother.

Claire remembers one of the men at her prenatal class saying that he is a doctor and that he delivers babies. *"And the midwife said, 'no, no you don't...' Basically she reminded us that we delivered our babies. I think she was giving this back where it belongs, because in some ways, we have lost that."* Claire speaks of this discovery of ownership. Women have always had the physical power of reproduction, but this ownership is easily forgotten in our healthcare system. Many women believe that they cannot get through these experiences of pregnancy and birth without the professional expert taking charge.

The midwife is also a healthcare professional, yet she *reminds* the class of their ownership. She did not tell the class that she is the one in charge, who will in some circumstances, *allow* the woman to take some control. Laurel said *"the biggest bonus about having a midwife is that they do not have ego attached to birthing, an 'I delivered this baby' attitude. The birth still belongs to the mother and the midwife has a critical supporting role. But the midwife is not the star."* The midwife maintains a constant vigilance that she is not assuming ownership for the woman's experience. Rachel recalled two clients who moved prior to their subsequent pregnancies and had no choice but to have hospital births with physicians. The birth stories they told to Rachel alerted her to issues of ownership. One woman had a breech birth that went very well. She was pleased except that *"because the baby was breech, they cut the cord right away and put the baby on a warmer. They said "good job" to the doctor.* ***NO ONE*** *ever acknowledged that the mother had the baby 22 minutes after she got there."* The other woman also had a relatively easy birth, but was annoyed with the nurse who actually caught the baby. *"After the placenta was out, the nurse wrapped the baby up and took it out to show to all the nurses at the desk. The nurse was proud of her job - 'look at the big baby* ***I*** *delivered'."*

In Her own Time

Aiden - I never felt rushed

> *With my first birth, I started labour during the night. I called my midwife, Melanie when we thought it was an appropriate time just to say that something might be happening today. She decided that she would*

grab the backup midwife and bring some reading with her and just come to see how things were going. As soon as they arrived, we went out for a walk and had our quiet space.

With my second birth, even though it was a much longer labour and we lived closer to Melanie we still spent the whole first day pretty much together. That evening, we discussed what was happening and where the labour was going to go. By then the labour had slowed down and so she went home and we all had a sleep. The next morning she called and said "well, why don't I come over and we'll see how things are." And we decided that things were happening well enough that she should stay. She was there for us and it was casual and we never felt rushed or that she had other things that she had to be doing.

With Brock's birth, I was feeling as though I could have an even greater say in what I wanted for the birth. I thought that once his head was born that I might do the rest of the birth myself. But he was a big baby and we had a bit of a struggle with the shoulders. It was nice to have her hands there to help with that. Kate's birth for me was more physical - it was a real feat, a real confidence on a physical level. With Brock, I think I was able to achieve more spiritual or emotional feats. With his birth, I didn't have any concerns about "would I be able to do it?" It was more kind of trying to create an environment with friends, with support and with a ceremony afterwards which would bring back some ritual to my birth.

There is no evidence that being at home does anything to decrease the length of labour. In fact, some studies suggest that the average length of labour is longer among women who birth at home than among those who birth in the hospital. In the hospital, the clock rules the labour. If the woman does progress according to standardized norms, interventions such as intravenous hormones are used to speed up the process.

The "birthing clock" used at home is the one set by the woman's body and the everyday events of home life. Midwives who attend homebirth are committed to the natural process of labour and birth and are content to watch nature take it's course. The events that mark time in the hospital such as routine assessments, shift changes and lunch breaks are the everyday life of the hospital, not of the woman. At home, the woman is free to mark the passage of time in ways that are meaningful for her. She may recognize the time of day, or passage of time

by familiar sounds or events like the clock radio, the neighbour coming home from work, or the arrival of the newspaper. A woman may check the clock when she feels that first "real" contraction signalling the onset of labour. Early in labour, the time from one contraction to the next may seem forever as the woman tries to decide if this is really "it." As labour becomes intense, there may not be enough time between contractions. It seems like forever since the beginning of labour, yet somehow the night flew by. Others may keep track of clock time for the woman. Lea know that it took her 26 minutes to push out her son, but at the time, she was not conscious of the passage of time.

Van den Berg (1970) suggests that our sense of time is associated with change: change of light, change of colour, change of place, change of plans. Time is important. *"How long?" "How long until it's done?" "How long until I push?" "How long should I try this?" "How long should I stay in the bathtub?"* What kind of answer does the woman want? An answer built on clock time may seem the kindest answer, *"only one more hour."* But what is that hour? Thirty more contractions? An endless sea of pain? A blink of an eye? Not long enough, I need more time? Too long, I can't bear it? The answers the midwife gives are connected with body time. *"When your body is ready." "When your cervix is open." "When you feel like it." "When the next contraction comes."* Time, for the woman, is marked by the changes she feels: a time for sleeping, walking, crying, pushing, rejoicing. The woman is encouraged to "listen" to her body for the time cues. The inward focus makes the "usual" time passage cues less important. The woman may not have noticed the beautiful sunrise that informed the rest of the world that yet another day has started. The woman may connect her sense of passing time to other familiar activities. Irene compared her labour to a day of work *"it felt just like six or eight hours of very hard work. Just like going to the office and coming back home."*

When we listen to the birth stories of women like Claire, Meg, and Aiden, we recognize that the woman's concept of the time of her birth reaches far beyond the few hours (or days) of the labour and birth process. For some

women, the birth experience may include the months of her pregnancy and even her plans to become pregnant. For others, the celebration extends for months or even years. I recently had lunch with Claire. Baby Aimee is nearly two years old. Claire told me that she wishes she could afford to have more babies, if only to capture that experience again. As I listened to her voice soften and her eyes grow misty, I recalled her birth story. This isn't an experience with a clear beginning and end, it extends on and on, into all aspects of the woman's life.

The Birthing Body - Childbirth "Naturally"

Trust in her body is of primary importance for the woman choosing homebirth. At home, the woman and the midwife must prepare for what it means to give birth naturally. The "natural childbirth" movement has brought a range of understandings of what giving birth "naturally" means, from the joke *"natural childbirth means doing it without makeup on"* to the vision of a wild woman birthing completely on her own. For some women, the idea of natural childbirth is frightening. On a recent television health show, the pain of childbirth was compared to having one's leg amputated without anesthetic (CBC, February 5, 1997). In the video *Born at Home* (1993), Carolyn DeMarco recalls an obstetrician telling her *"nature would tear the woman apart."* Other women are angered by the approach of some within the natural childbirth movement. Women following the teachings of Grantly Dick Read and Fernand Lamaze learn that the pain of childbirth is not "natural" and if the woman would only prepare herself in the correct way, she will not experience any pain. In the decades following the introduction of these approaches, many women have left their birth experiences feeling tricked, unsupported, perhaps even as a failure (Cosslett, 1994). Closely linked to this approach is the somewhat romanticized version of natural childbirth. The media fills us with images of women who work in the fields through their labour and give birth on their own (e.g. O-Lan in *The Good Earth*, Buck, 1931) or who give birth painlessly in isolation such as the !Kung women of Botswana:

> The ideal birth begins in labour when a woman goes alone out into the veld and finds a shady spot, close to the camp in case she needs help. She arranges soft leaves for the child to fall on to, and as labour intensifies she listens to her body, telling herself not to be frightened, feeling as her baby fights its way into the world. (The Body Shop Team, 1991, p.68-9)

These natural childbirth stories may also bring the woman to question her experiences of pain and of needing support.

Birth at home with a midwife does not mean retreating into the wilderness to birth alone. Nor does it mean that the birth will be painless. However, the lack of pain medications and epidurals, forceps and cesarean sections at home become a serious focus of consideration. Throughout her pregnancy, the woman confronts her beliefs about her body's capacity to birth. This is a particular challenge for women having first babies or who have previously had a cesarean section. Mutual trust in the midwife, in the woman and in the birth process is needed to birth naturally. Lea said she decided to try to have a vaginal birth for her second baby because *"I really had confidence in my body, because I knew my body worked really well and I was really healthy. I knew that I'd be fine."* Each woman's story conveys the reality of her birthing pain. Claire said *"this really hurts, what an idiot I was to think it wouldn't."* Alice said *"Margaret told me I could feel the head. I never did. I was in so much pain, I didn't want to touch that area."* And yet, the experience of facing birthing pain can be incredibly powerful. Lea said *"it was a part of me I had never met before. It scared me, it was a really powerful part of me, that before the birth, I would have never believed was there. I just followed her. I just did what she was telling me to do, be naked, make noise, I made great noise."*

In hospital, there is a tendency to concentrate on the baby in the woman's body. Continuous electronic fetal monitoring may take precedence over the woman's desires for finding a comfortable position, walking or being in the shower. The woman's body is often viewed as a hostile environment for her baby. Moaning and crying in labour are seen as disturbing and are responded to

by offers of medication or epidural. Women may be coerced into complying with the desires of the caregivers, usually through threats of "we wouldn't want to do anything to harm that baby, would we..." or "you cannot be in the hands and knees position, the baby could fall, you could tear..." The ultimate separation of woman and body is the epidural. The woman is disconnected from all sensation of the parts of her body involved in birth. Her body becomes the machine that does the birthing, often with much assistance from the physician (Davis-Floyd, 1992; Martin, 1987).

Pregnancy, birth and lactation call a woman's attention to her body. Rather than living through her body, she lives with her body, constantly aware of her changing shape, the movement of the baby within, the discomforts that accompany pregnancy, and the gaze of others who may think she is too big or too small or too public with her breastfeeding (Gadow, 1993; Young, 1984). Labour and birth demand a particular consciousness. It is impossible to ignore the intense contractions, the bursting of amniotic membranes, the involuntary pushing, the "ring of fire" that accompanies crowning of the baby's head, and the heavy slippery warmth of the just born baby on her belly. The midwife invites the woman to claim this birth as her own by listening to her body cues, to follow these, to report them to the midwife. For some women, this experience of awareness is new and exciting. Diane spoke of her reaction to her first contractions: *"I went into the bathroom so I wouldn't wake Paul. Oh finally, finally, finally, finally!!! And I was just so excited that I found it hard to sleep, I was dancing around in the bathroom."*

The focus on the woman's body cues may lead woman and midwife to objectify the woman's experience of her body thus alienating or separating her from her experience (Gadow, 1980, 1993; Young, 1984). In our attention to the dilation of the cervix, the descent of the baby's head, the frequency of contractions and the colour of the amniotic fluid we may be able to "forget" that these processes of labour and birth occur in the woman. We could concentrate on each aspect of these processes as though each is an independent

mechanical function (Martin, 1987). Cynthia described her first birth as an experience of having things done to her: monitoring, intravenous augmentation, and forceps delivery. Perhaps, these procedures were not even done to *her*, to Cynthia as a person, but to Cynthia's body. Her body, the machine, was not doing it's job "correctly." It needed expert help.

The tone, *attention to the lived body*, is loudly heard throughout the birthing process. The woman's experiences with her midwife up until the birth inform her that the birth experience can also be about her, not merely about the functions of her body. The labouring woman is in a familiar place, surrounded by familiar people. Her body calls her attention to experiences that are painful, that are pleasurable, that are frightening, and that are welcomed. Even when the experience of labour and birth is completely new to the woman, she has other experiences in this place and with these people to ground her, to remind her *this is about **me***. She is able to decide what position to assume, when examinations will be performed, who will touch her, and how. Yet she is in an environment that gives her the security to relinquish control to her body and allow labour to happen.

Midwives realize that connecting self and body, is important in the work of birthing. It is the woman who gives birth. It is not just her uterus, not just her cervix, and not just her vagina. At a perinatal research meeting, the presenter summarized labour as the product of three processes: cervical dilation, uterine contractions and rupture of the amniotic membranes. When I asked *"what role does the woman herself play in labour?"* I was told that she is a passive participant. Yet, I reflect on stories such as Alice's where she stopped labouring when certain family members came to her house uninvited. I recall experiences from my own practice where women go into labour the day after their partner returns from an out-of-town business trip and where women "wait" to feel like pushing until the midwife arrives. Coincidences? Perhaps. And yet, the women tell us *"I didn't want to do it without him..."* Sometimes the connection of self and

body comes completely through the woman, sometimes the midwife plays a role in reminding the woman.

Laurel - Ground yourself

> *I remembered thinking "I can't, I can't I can't." And the midwives said "you are." The words they chose made me realize that I was pushing. I thought to myself if I just smarten up and give one decent push then all of this would be over, we could end this, but I seemingly couldn't. Then the midwives asked me "what do you want to do?" I was sort of on my back and on my side and I grabbed Holly and she said "ok, that will be alright then." I squeezed the stuffing right out of her. And then, my daughter was out. I just need someone to be patient. When I'm weeping I need someone to say "this is normal, it means you're close!" I needed someone to say "it doesn't get much worse than this, you can last." Until you've pushed out a baby, you don't know how much worse it is going to get and I thought if it gets much worse than this, I'm not going to be able to do it. I needed someone to cut through the isolation and to do my thinking for me when I was pushing and all my brains had gone to my butt and I couldn't think. She said "Laurel, listen to me, push here" and she put her fingers there and she really directed my energy, but not in a cruel way. She just said "pay attention, come ground yourself here."*

Although the woman trusts and believes that her body will give birth naturally, it is always awesome that it happens! When we reflect on Chantal's comments about loving her birth and Claire's description of having a birth experience, we realize that birthing naturally is not an inconsequential natural body function. Birthing naturally is not of the same order as breathing or sweating. Each woman, each family, each midwife attaches meaning from their lives to this experience of birthing naturally. Lea described her reaction to Adam's birth: *"And when he came out, it sent me flying into a million pieces. It was incredibly empowering."* Madeleine described her second birth *"I was just cracked open and all this stuff was oozing out of me all over the place - emotionally and spiritually and so many other ways and I just couldn't put a lid on it and I couldn't understand it. It's a mixed bag of emotion and this intense sense of love."*

An intimate touch

> *We said in the hospitals they made us wear leggings, they had wrapped our bodies, they had claimed our bodies might infect our newborn children. And the room was cold we said. And the chrome frightened us. We said in the hospitals we would have liked to have removed our clothing. We said that when we chose to trust this woman to attend to us, we ceased to believe our bodies would infect our infants. We said, as we trusted her more, we began to do what we had always wanted to do.* (Griffin, 1978, p. 199)

Labour and birth are intensely intimate experiences. The similarities between birth and sexual intercourse, the hormones secreted, the intensity and location of sensations, and the emotions involved, remind us that birth is an expression of the woman's sexuality (Bing & Colman, 1977; Davis, 1994; Kitzinger, 1983; Newton, 1992). Perri said *"you cannot drop all the functions of the vagina and pretend that it is only one. I had obstetricians and I certainly thought about it when he was putting his finger in my vagina. Birth is the same as with sex - if you let go into the emotions, there is a lot of energy. You look inwards and get into the birth rather than paying attention to the outside stuff."*

While not every woman identified her birth experience as being sexual, each birth story reflected the intimate nature of birthing. When we think of intimate experiences, we generally think of those shared with others very close to us, friends, family, lovers. An intimate experience is one which "is connected with the inmost nature or fundamental character of a thing, pertains to the inmost thoughts or feelings, affects one's inmost self, and is closely personal" (Oxford English Dictionary, 1990). The birth experience is connected to the very centre of the woman's self and in birthing, she exposes herself physically and emotionally. The woman may chose to escape the intimacy but she cannot escape the birth process.

Until recently, women giving birth in hospital were completely disconnected from an intimate birth experience. Their hands were tied, their legs strapped in stirrups, they were draped so only the physician could view the emergence of the baby, they were often drugged or even anesthetized (Cosslett,

1994). The woman making sounds was hushed. The woman touching herself or her emerging baby was scolded. While hand tying and anesthetizing are no longer used, we continue to hear the discomfort of healthcare professionals with the intimacies of birth. Fiona Hanley (1993) wrote an article in the *Canadian Nurse* about midwifery and homebirth. Included in the article were photos of a woman giving birth. This article stimulated a series of letters to the editor of the journal criticizing the decision to publish such "distasteful" photographs. Last year, the Alberta Association of Midwives produced a short video about midwifery to use for educational purposes during the midwifery implementation process. The video shows midwives in all aspects of their work and includes a very brief clip of a birth. When it was shown to a small group of healthcare professionals and regional health authority representatives, the reaction was overwhelmingly negative. *"There is too much nudity"* they said. The video will not be used for education of healthcare professionals in this province.

At home, the woman experiences this intimacy in a way that is comfortable to her. As Susan Griffin (1978) suggested, with trust, the woman feels free to follow her instincts. Many women are initially surprised at how readily they shed their clothing, how easy it is to sit naked in the pool with midwives, friends and family around, and how fascinated they are to see their birth photos exposing their most intimate parts. Diane said *"I'm not very proud of my body and so I tend to keep it covered up as much as possible at all times. But there was such as feeling of support and acceptance from the midwives that by half way through, I was completely nude and it didn't bother me in the least."* Patricia said *"when I sat on the birthing stool to push, I took my shirt off and I was totally naked. And at first I thought, 'oh, my shirt is gone' but once the next contraction came, it didn't matter."* Theresa said *"I chose to give birth with a dress on. And at the end of the birth, after the baby was born, I just removed my dress so I could breastfeed. The dress was full of meconium anyhow. At that point, I had gone through a threshold where I felt comfortable."* Christie said *"As my labour progressed, I just took my shirt off, it seemed the natural thing to do.*

Now that I've had a homebirth, I've become much more comfortable with my body, it's like freeing up my sexuality. I have some of my birth pictures on my living room wall!"

Midwives are also conscious of the intimacy of the birthing experience. They recognize that this is when a woman is most vulnerable, when it is possible to overstep the boundaries of what is acceptable touch, acceptable gaze, or acceptable words. With the exception of measuring and palpating the woman's belly during pregnancy, most midwives have not viewed the woman's body unclothed until the birth. Kathleen explained why she finds women are seldom embarrassed by vaginal examinations or the birth process: *" I think it's because I'm in her home and she knows me and she knows that she always has a choice about examinations or how much she wants to expose."* Rachel identified a feeling of self consciousness when first entering into a woman's intimate space at a birth. She is aware that this may be the first time she has seen this woman naked or has heard her moan or swear.

Touch is used extensively by most midwives throughout the birthing experience. Touch is an extremely intimate form of communication that is both a way of being together with others and of being oneself (Buytendijk, 1970). Some touch is for comfort or pain relief: putting pressure on the woman's coccyx when she has "back labour," massaging her shoulders or legs, holding warm compresses against her perineum while she is pushing. Other touch is to "ground" the woman, to call her back to the experience: perhaps holding her feet, embracing her in a hug, or holding her hand. Other touch is a measure, a feel for where this woman is in her labour (Birch, 1986). It may be difficult when the woman does not want to be touched. Other touch is more "instrumental," the touching required to auscultate the baby's heartbeat, to assess the dilation of the woman's cervix, to free the baby's shoulders at the birth (Weiss, 1988). All these forms of touch have the potential to make the woman feel vulnerable, to feel objectified. Sally Gadow (1984) speaks of empathic touch, a way of "affirm[ing] the subjective significance of the body for the patient. Its purpose is not

palpation or manipulation but expression - an expression of the caregiver's participation in the patient's experience" (p.67). To touch empathically requires an attention to *this woman*, to what is acceptable, and to what is desired. Midwives speak of testing and of asking permission to touch. Rachel said *" I usually say, do you mind if I show you this. I might start doing some massage and ask her to tell me if it is ok. If it is during the birth, I ask her if she wants to touch the baby's head."* Women sense when touch is empathic. Jane said *"Carrie was rubbing my back and I knew she would use a different stroke on somebody else because of how she knew them. It was a good feeling that Carrie was doing this just for ME."*

In order for the midwife to really participate in the woman's experience, she too must stay connected to her body. This may be in tuning-in to her body cues that add to her knowledge of the situation. Of equal importance is staying aware of the possibility of treating her own body as an object, a machine. The midwife's hand may perform great tasks, but seen as an instrument rather than as the midwife herself, the midwife is at risk of stepping away from this experience. If the midwife thinks of her arm as a lever or her shoulder as a leaning post, she does not engage herself with the woman. She too is at risk of visualizing herself away from a very intimate bodily experience. I think of the times where I am sitting on the woman's bed prepared to catch the baby. My legs are intertwined with the woman's, providing her legs with some support. I am sitting very close to her. I can feel the strain of her muscles as she pushes the baby. I can smell the blood and amniotic fluid that are running toward me, so far being caught in the pads I've placed beneath her. I could easily concentrate on the emerging head and ignore the woman, ignore our closeness, and our touching. But in ignoring the woman and myself, I do not engage our intersubjectivity, our way of reaching one another as ourselves (Gadow, 1984).

Body with baby - one becomes two

The baby in the woman's body is separate yet connected to her. The woman's way of knowing her baby throughout pregnancy has been through her

body. Staying connected to her body experience during birth also keeps her attuned to her baby. For some women, it is a strong sense of connection. For example, Diane found a connection with her son during a visualization exercise at the midwife's prenatal class. She said *"I felt so close to the baby that I thought I could check to see if it was a boy or a girl but at the moment it was absolutely not important to me."* In labour, this connection of woman and body, woman and baby, may provide the woman with a knowledge of her baby's wellbeing. When Lea was pushing her son out, his heart rate began to drop. Her midwife suggested that she could do an episiotomy so he would come out soon. She said *"I closed my eyes and I knew I was being told that he was fine. I told the midwife to put down the scissors. He came out on the next push."* The woman is highly aware of her bodily experience of the baby's passage into the outside world. It is though her body that the woman first gets to know her baby after the birth. Diane described that knowing: *"Suddenly he was in my arms. I felt him in my arms and he felt so heavy to me and there was a hot sweet smell that was coming from him."*

A Family "birth experience"

Camille - You're doing such a good job mommy

> *I was caught quite off guard when I went into labour. I have no idea why, I was overdue. We were in the grocery store in aisle 7 and suddenly I get these huge pains. BOOM just like that! These were no Braxton Hicks! I just hunched over the cart. I couldn't walk. I thought "I'm going to have the baby right here in Safeway!" And I said "Terry, I can't move." And I'm in aisle 7 hunched over the cart and he was running up and down all the aisles in the grocery store. We were at the corner of the aisle and there was candy and Jason said "mom, I'd like some gum." And instead of saying "no, we're going home, leave it alone" I gave him a big long answer.*
>
> *We got home and Terry asked "do you think I should phone somebody?" And I said "yes, I think you should phone everybody." So he phoned my mom and dad and Gwen, the midwife. I was feeling rushed and a little riled. When Gwen arrived, she suggested that I try a bath. We ran some water and she started to really nurture me and care for me which calmed me down. It was a kind of confidence - a kind of "don't worry, I'm here and I'll be with you." We spent lots of time in the*

tub. All of us - Gwen and the other midwife Leslie, Terry and Jason were crowded into that bathroom. And that was interesting to me that the midwives would stand in this crowded little steamy space just for me. I noticed that there were different times when Gwen or Leslie noticed things so I didn't have to ask. In the bathroom, there was a little candle and Gwen said "to do you want me to light the candle?" And it just meant so much to me - it was something that I had wanted. It was just a feeling that I was seen in some way. She poured water on my belly. She just knew how to nurture, how to care and comfort. I really needed that because a part of me didn't feel too in control. And then there was little Jason - it is a thrill remembering him. His little face and dumping water on me and giving me popsicles. He would touch my shoulder and say "you're doing such a good job mommy." And he was so calm. I think we had done a pretty good job of talking with him and preparing him.

Birth brings a new member to a family. As home is the centre of the world of the family many women have a strong sense of family in the planning of a homebirth. Family approval is important. Many woman who have a homebirth do so without support or approval of parents, siblings or extended family, but it is difficult for a woman to go ahead with her plans if her partner is unsupportive. The woman and her partner share the space of their home. When the partner is supportive, that support is felt throughout the home. When the partner is not supportive, the woman may not be able to find a space in her home where she can escape that feeling of no support, even if the partner is not present.

Continuity of Family

When birth occurs at home, the new family member arrives into the centre of the world of the family. There is never any question of mixing up babies. In hospital, women are often expected to relinquish their baby soon after birth. Irene had her first baby in hospital. She described that early separation: *"I had these feelings of being abandoned and that they stole my baby."* At home, the baby is held by the woman for as long as she wants before even basic assessments like weight and examinations are done. It is up to the woman to announce the gender of the baby. When she is ready, she'll look under the towel. This is her baby, her news. The woman is able to introduce her new baby to the rest of the family and to create a space for the baby in the family. Cathy's

daughter Celine was sitting beside her when she gave birth to Kevin. She said *"when Kevin came out, I knew I loved him right away, and I know I said it. At the same time, I turned to Celine and hugged her and told her how much I loved her and was glad that she was there. I didn't want her to feel replaced by Kevin."* The woman's deliberate activities to prepare for the birth and the inclusion of family helps to strengthen her role as mother. Many women recognize the strength and confidence required to get to the point of birth and use these qualities to move into caring for her new child. Lea said *"instead of having to doubt my confidence level with my baby and always wanting someone else to tell me what I should to do, I was free to discover what to do and to do it."*

In our society, we have come to expect the presence of the partner at the birth. In hospital, partners are often expected to be both the supportive labour coach, providing care to the woman, and to stay out of the way of the work of the professionals. At home, the involvement of the partner is much more intimate than it could ever be in the hospital. The way that touch and words are expressed is different in the privacy of one's home than in the public place of the hospital. At home, a closed a door is respected, the couple may be together in a way that is comfortable to them. In the hospital, the door is the property of the staff, not the woman and her partner. A closed door may be questioned. At home, the involvement of the partner is defined by the couple, not by the rules of the institution. Some partners want to catch their baby. Others want to get into the birthing pool to sit behind the woman. Some are very nervous and need many opportunities to get away from the intensity of the birthing experience. Many men are moved in surprising ways through their involvement at the birth. Madeleine explained *"I've seen men too where all of a sudden the birth experience has really stimulated their feminine side. I remember there was this one fellow who just wept for the week after."* The continuity of the couple's relationship and the involvement of both in the planning and in the event strengthens their bond and their relationship with the new baby.

The involvement of family often extends beyond the partner. Many women choose to have other family members or other children present. For women, like Megan, having her children present was a major factor in her decision to be at home. The arrival of a new sibling can be a confusing time for a young child. The woman has already formed a strong relationship with that first child. If she goes to the hospital for the birth of the new baby, the child may question why her mother left and why she had to bring a baby home with her. The woman herself may feel the tensions of her existing love for the older child and her developing love for the new baby. Although a physical space has been made in the home for that new baby, a relational space may take longer to develop. The arrival of the new baby creates chaos in the order of the existing space. The home as a birthplace creates early beginnings to the development of a relational space for the new baby, a place of security within the children's orderly and trusted world (Bollnow, 1989b). Children often sense the magnitude of the birth event and sense a particular trust that their mother must have in them. When we listen to Camille's story of Jason's actions and words during her labour, we recognize that children are intuitive to their mother's needs and capable of responding to those needs. Lea's 3 year old daughter Annie was present at her birth. Lea described her experience: "*her eyes were as big as saucers. After the birth, she told me 'I saw Marcie (the midwife) put a bag on her hand and take the baby out.'*" Christie's two preschool aged children sat on the lap of the backup midwife Kelly while Christie gave birth on her bedroom floor. She believes that their participation brought them close to their new sister and to one another. She explained "*My son, Ryan grew up some at the birth. I can remember him saying such adult things to me trying to comfort me. He had never done that before. And he still carries his picture of one of the midwives. He tells everyone "this is Kelly, the midwife." And when my daughter got her puppy surprise for Christmas and pulled out the puppies from the mother dog, Ryan said, 'oh, Peggy you're a midwife.'*"

Being known

The woman having a homebirth is attended by family, friends and midwives who know her. She has already spent hours with her midwife, discussing her plans, her fears, her excitement. The experience of being known brings the birthing woman closer to those around her. Her relationship with others takes on a deeper level of trust and respect. In hospital, nurses and doctors call the woman by her name. However, the nurse just met the woman at the time of admission, or at the beginning of a shift. The doctor has had longer contact with the woman, but generally only on a superficial basis, and only on "his turf." The woman is not known there. Practices such as using the woman's first name or endearments such as "sweetie" or "good girl" may give an impression that the woman is known in hospital. But naming practices based on hospital hierarchy ultimately create barriers to being known (Bergstrom, Roberts, Skillman & Seidel, 1992).

Because she is known, the woman is able to gain support, both physical and emotional. The presence and touch of others brings a sharing of the experience. Anne considered doing her last birth on her own. After all, she is an experienced midwife, she has the skills and knowledge to do so. However, she recognized that she did not want to be on her own. She explained *"I wanted people to be there. I think that most women having babies need to have people there just to be there - to marvel at them as they are going through this wonderful experience."* The midwife creates a woman centred experience. She knows the woman and understands her vision of her birth. In hospital, the technical aspects of relationship building can be present - the naming, the interest in choices, and the recognition that each woman is an individual. However, the limits to the relationship building are artificial to the woman, based on institutional rules, not always even relevant to safety or health. The language of the hospital can be contrasted with home. At home, the woman gives birth. In the hospital, the physician is in control and delivers the baby (Davis-Floyd, 1992; Kelpin & Martel, 1984).

Many women speak of another relationship, the connection with women, that is developed through the homebirth experience.

> *Again I was pioneering, again I was strong and in control. There was a pleasure in doing something I was good at. There was nothing to rely on here by myself and Tobie and Sam: no medications, no surgery, no anaesthesia. Just me and my body. For a minute, I thought of my own mother, lying drugged and unconscious in a hospital while they dragged me out of her with forceps. I did not want that. I wanted to be awake, to be the Creator, to give life. (Sexton, 1988, p.45)*

The atmosphere created by the comfort, safety, respect and love at home is one in which the woman can move, grow, and discover herself spiritually. During her birth, Lea found herself questioning what it was to be a woman. She had a profound spiritual experience, one that she believes could never have occurred except at home where she felt totally safe and respected. She explained *"I felt a presence about me that I had never felt before. This was definitely a connection to women, and it felt very old. It was almost like I had a guide."*

Inviting is a gift

The invitation to a homebirth is a very honoured privilege. Women at home employ their position as host to carefully orchestrate who will be around her for the birth. It is vital to create an atmosphere of trust, patience, respect and love (Bollnow, 1989b). Many women use this very special experience as a way to share the power of being a woman with other women and to bring back the lost traditions of birth as women helping women. Cathy invited her mother-in-law's sister because she had never seen a birth. She explained *"it's like a gift I can give, from one woman to another."* Yet, the host role can sometimes result in having people at the birth who are not right for creating a comfortable birthing experience. Theresa felt obliged to invite Drew's sisters even though she is not comfortable with them. She believed that this affected her experience and plans to have her next birth with only Drew and her midwives.

Midwives also respect the invitation to the woman's birth. While the midwife realizes that she has a very special invitation, she is a special guest, she

is not the guest of honour. This is an occasion where the attention is focused on the woman and her family. Often as the midwife leaves, she hugs the woman and tells her *"thank you for inviting me to your birth."* Rachel, like most midwives, sees the invitation to birth as a privilege: *"Birth sometimes is just like an overwhelming high. I have a sense of it being a really holy experience. It's like that feeling of being at a slumber party - a woman's bonding sort of thing. There is a permanent bond there that comes from going through that heavy space together, seeing each other through it and for me having the honour of being there."*

Birth-day as celebration

Homebirth is a celebration - of birth, of family, of women. Celebrations are festive occasions that are distinct from everyday life and only occur when there is an active participation of people who have a sense of relationship to one another and to the event (Bollnow, 1989a). Homebirth takes on the qualities of a celebration: the inviting of guests, the participation of all the players, the development of a sense of community and togetherness. Although couples experiencing birth in hospital may feel joy in their experience, the experience itself is unlikely to take on the mood of celebration. Hospital birth is more like a ceremony, which occurs regardless of the participation and relationship of the players. As long as the woman presents herself at the door of the hospital, she need to do little else, the ceremony will go on without her.

Many women plan a party following the homebirth. This can be an intimate event, often only involving the partner and the new baby. For others, it is a big event, thoughtfully planned. Diane had her party catered. Megan had a birthday cake in the freezer, which came out to thaw when labour started. Molly phoned several relatives and ordered pizza within an hour of her birth. The house was full of family having a good time sharing the celebration of the birth of her daughter. For children who are involved in birth, the birthday party takes on a whole new meaning. They realize that this is not only a day that occurs each year when they get gifts. This is a day that is special for the whole family. For

the woman, the birth-day is a celebration of her power as a woman, her connections to her family, her friends, her caregivers and to women.

As we listen to women and midwives tell of birth experiences, we gain a sense that something profound has happened to the woman, to the family, and to the midwife. This is not a magic formula of painless labours, candles and music. Even the hardest, longest births, the ones where hospital transfers are required, and the ones where the baby does not survive can remind us of Chantal's love for her birth and Claire's "birth experience." The birth experience is a profound intersubjective meeting of women, partners, children, friends and midwives. I occasionally hear midwives saying *"I need a birth."* That opportunity to take part in this very human experience reminds us of ourselves and our relations to others and to the earth. In a scene in the video *The midwife's story*, we see a group of midwives sitting around a table talking about their practice. One midwife who has stopped doing homebirths asks the other two if it ever gets boring to attend births. The two look at one another and their eyes glaze for a moment. They are remembering. Their simple answer is *"no."*

Chapter Six

Friends, Sisters, Mothers and Angels

Theresa - Am I going to have a good friendship?

> *When I first went to Irene, all I wanted to know is "am I going to have a good friendship?" I cared more about the friendship than her services. I cared about feeling comfortable, being able to talk about the most terrible thing or the most beautiful thing and I wanted her to be there for me. I wanted her to be able to hear what I say, no matter what she thinks and respond to me with care and love and be careful not to hurt my feelings. I found that in Irene. At the first visit, we chatted there. And she laughed a lot and I laughed a lot. And then I decided that I wanted to see her as my midwife. I wanted Irene to be my friend for life, but I actually didn't get that because after my first birth was over, we didn't see each other for two years until I got pregnant again. But now, I see her as a true friend. I see Irene not as a friend who I would go to the swimming pool or a barbeque with but as a friend that I can talk to. What makes me think that Irene is a friend is that I am no less than her, she gives me the importance that I give to her. To me, Irene has a big importance in my life. My husband and I talk of her like a pupil would talk about a teacher. But even so, I feel as though I hold this rank of importance as well.*

This month's picture on my Laurel Busch calendar is "Rainbow woman dancing." Beside this very colourful woman is a list: teachers, mentors, elders, mothers, daughters, friends, guides and angels. This is very much like the ways that midwives are referred to, by one another and by their clients. My midwife, my friend, like a mother to me, a sister, a guide, a goddess, an angel, and batwoman. The relations experienced between midwife and woman are intense ones. The words used to describe them reflect this intensity. Some may challenge the need for this list. Women experience midwifery care, a form of care that may evoke familiar feelings such as those experienced with close friends or family members. And yet stories such as Theresa's bring us to question the possibilities of friends, mothers, sister, angels within the relation of being *with woman*.

A Midwifery Community - Finding the Boundaries

As I negotiated the hills at the Edmonton Folk festival, I frequently spotted the faces of women and families I know from among the sea of 15,000 or more. So much of my life in this city is attached to being a midwife that most of these familiar faces are ones I've met through birth. I frequently met Beth who is due in just three weeks. She asked if I have my pager and teased that she will have her birth in the first aid tent if she goes into labour this weekend. She doesn't think that either of us should have to miss the performances. I met Maura who, like always, is so enthusiastic. It is more than a year since her birth, yet she still has that amazement and excitement in her voice when she speaks of her children, her births and her midwives. She introduces me to friends and family. *"This is Susan, one of my midwives."* I see understanding, warmth and acceptance in their faces. She tells us that she wishes she could have a hundred babies. I watch her keeping an eye on her three year old son as he runs around on the hill and occasionally touching her baby daughter as she sleeps on Maura's back. As we walk through the crowds, my friend who is visiting for the weekend tells me that she is jealous. She is amazed at how close I am to these women who I spot in the crowd. She begins pointing to pregnant women and women carrying new babies and asking if she is also one of my clients. She asks how I can remember them, their names, their children's names. She wonders how I knew about Maura's family holiday, Jenny's new business, or Heather and Dan's divorce.

Midwives and midwifery consumers often speak of the "midwifery community" - a community made up of midwives, women, partners, children, other relatives and friends who have experienced or support midwifery care. Letty Cottin Pogrebin (1987) suggests that one of the preconditions of friendship is proximity. We must be in the same physical space for friendship to occur. Perhaps my walk through the grounds of the folk festival is not unlike the experience of meeting friends and acquaintances from your neighbourhood, from your workplace or from your church. While we are not a geographic community like the neighbourhood block, we are an experiential community, having shared

in a common experience, having similar values and beliefs. People and "place" become inseparable in matters of friendship. It is through the connections and networks that are made within our activities in our communities that we come to know others. And, it is through knowing others that deeper relationships may develop.

At the folk festival, I met Elaine, a midwife from another practice. While Elaine and I do not work together, we are friends. She is talking to one of her clients while waiting in line at a food tent. She introduces us and then the conversation starts again. I am an insider in this community, Elaine's client somehow knows that I can be a part of this discussion about her worries of being overdue again this pregnancy. Our "place" is not the folk festival, or even Edmonton. It is a place where what it means to have midwifery care is understood. Elaine's client and I do not assume a friendship based on our common membership to this midwifery community. However, a small door is opened allowing this discussion because of our common experiences, common understandings.

In some cultures, the midwife has a very special role in her community. In First Nations communities, the midwife is treated with honour and respect. It is the responsibility of the community to ensure that the midwife has food, clothing and shelter. And, the midwife returns that responsibility by assuming a form of connection or responsibility for each child she helps into the world (Anne Bird, personal communication, May, 1996). One midwife, Kira, spoke about the customs in the country where her boyfriend was born. *"When he goes back, he always goes to visit his midwife and she always says 'oh, you got so big.' It is a custom to show respect to your midwife."* In Canadian culture, there is not a formal custom of respect to the person who attended our mothers at our births. Few of us even know who that person is. In some ways, the midwife or midwives pull the "midwifery community" together. It is the midwife who is the common element - the women themselves may not know one another, may not recognize a fellow community member when standing in the grocery store line. And yet, it

is not a midwife centred community. In larger cities, there may be many midwives, each in their practices with their own smaller communities within the larger community. But, when women find one another, perhaps when asked what hospital they went to or which doctor they were seeing, and quietly answer *"I did it at home"* or *"I have a midwife"* there is an instant recognition, a feeling of common experience. It doesn't matter that they don't share the same midwife.

I sometimes find the unknown connections within the community to be amazing. In the past week, I discovered that four of my clients, all due within a span of two months, have connections to one another. These are not strong connections, some did not even know that one or more of the others were pregnant. Perhaps there are other communities that overlap with the midwifery community, sharing many of the beliefs and values. There isn't a particular "stereotype" of the woman who seeks midwifery care, however, there are large proportions of women who home school, women from particular church groups, academics, artists, and women from some neighbourhoods. In my practice, we go through phases where many of our births occur in the same area of the city. When we start to look at the characteristics of those neighbourhoods, we find that it is often the family centred reputation of the elementary school or the strong sense of community cohesiveness and activity that attracts new families to those places.

Perhaps the midwife sets the atmosphere or the tone of the community. The overall approaches of woman centredness, providing time, and feeling at home are what the woman experiences when she first makes her decision to enter the community. Once the woman is drawn into the community by her choice of having midwifery care, she may bring others into the community: her partner, her friends, her children, her parents and so on. And like any community, the forms of relationship are diverse, and the strength of the sense of belonging or the desire to remain a part of that community for long periods of time varies.

Like any community, there is a possibility for friendship within the midwifery community. The word friend is derived from the prehistoric Germanic verb *frijōjan,* to love (Ayto, 1990). Love seems a very strong emotion to attach to a relationship between a woman and her midwife and yet women such Alice, Camille, and Jane used it often when speaking about their relations with their midwife. We use the words friend, friendship, and friendly frequently: the friendly giant, user friendly. It is often seen in advertising e.g., the plumber's friend or when referring to something "indelicate" e.g., a visit from a friend (referring to menstruation). And yet, even these casual uses of the term "friend" bring a sense of understanding that a friend is someone who supports us perhaps in a way that is very close or intimate. Our understandings of friendship, who is a friend or under what circumstances friendship occurs are influenced by research in the social sciences and social or cultural norms or practices (Allan, 1989; Raymond, 1986). Descriptors of friendship usually include reciprocal, safe, trusting, intimate, supportive, loyal, generous, honest, and loving. The feelings of both people must be touched in such a way to bring about a deep level of connection. Yet it is not liking alone that makes a friendship (Hutter, 1978). Hugh Black (1911) described the depth of feelings or emotions in a "true friendship."

> The divine meaning of a true friendship is that it is often the first unveiling of the secret of love. It is not an end in itself, but has most of its worth in what it leads to, the priceless gift of seeing with the heart rather than with the eyes. To love one soul for its beauty and grace and truth is to open the way to appreciate all beautiful and true and gracious souls and to recognize spiritual beauty wherever it is seen. (p.24)

Some would question Theresa's claim of true friendship with Irene. A relation for the purpose of one person receiving a service from another cannot be a friendship, particularly one where there is an exchange of money for that service. This would be an "end in itself." Nor can a relation that goes into hiatus for two years between pregnancies and will have a natural ending when the woman decides she is finished with childbearing. Nor can a relation where there

is a clear power imbalance. And yet as we listen to Theresa's story, we recognize that there is more to their relation than a professional exchange of services.

Others may suggest that Theresa has misinterpreted Irene's friendliness as a friendship. Midwives use a friendly approach in their interactions with women. Perhaps the experience of giving and receiving midwifery care within a friendly atmosphere leaves women feeling many of the qualities of a good friendship without the commitments and responsibilities of a friendship. Usually the differences between friendship and being friendly are clear. For example, it is possible to be friendly to strangers and to people we don't even particularly like. A friendly approach may be reflected in various "informalities" in the healthcare setting: using first names, permitting self disclosure or social talk, not wearing uniforms (Hunt, 1991). And yet, a friendly approach may have little to do with intersubjectivity. The professional need commit nothing of herself to an other. A friendly approach may be applied generally, to *any woman* by *any midwife*. While we may leave an encounter where a friendly approach was used feeling as though it was pleasant, we are unlikely to believe that this encounter initiated a friendship. However, in being friendly, we reveal much of ourselves and who we are or what kind of person we would like to be within the context of our time together. Being consistently friendly opens the possibility of the forms of relationship we are willing to enter. Being friendly, for example, the laughing and chatting between Theresa and Irene on their first meeting, paves the way for friendship to develop when chosen.

Some friendships are already in place before women enter the midwifery community. For example, Alice and Claire sought midwifery care on the advice of friends who already had this experience. Some women seek the care of a midwife who is already a friend. New friendships may develop between members of the community. Other women such as Aiden are clear that they are not seeking friendship in the community, they have only entered the community to purchase a service. Other women, like Claire would like to see their

relationship with their midwives become friendships but are hesitant to assume that their midwife's friendliness implies that a friendship is possible. It would be difficult to imagine the possibility of friendships for all members of a community if the community is structured around forms of hierarchy. For example, it would be difficult for the "leaders" to be friends with the "others." It has been suggested that kings cannot truly have friends because they are not allowed to have equals (Pogrebin, 1987). Certainly, if the midwife were considered to be the "king" of the community, somehow set apart or above from all the others, it would be difficult for her to form friendships with the others within the community. However, friendship among midwives is not only common, but is essential to the work of midwives. In many cases, it may serve as a model of relationship. Midwives rely heavily upon one another to ensure that each woman gets the required care, to survive the stresses of being on call, and to support one another during the vulnerable times. Elise compares her relationship with Margaret, her current midwife partner and with her first one, Nola.

Elise - The matriarch

> *When I was working with Nola and a woman would come in, there was always a shift in the relationship between the woman, Nola and I. Nola was very much the primary midwife - she would always take the role of the matriarch. I would say something and Nola would always say something a little better. I was always under the eye of the eagle, always being watched. When it came time for the birth, everyone wanted Nola because she looked like she was the most knowledgeable, always in control and she looked like she was the ultimate mother. When I started to work with Margaret, she saw me as an equal right away. That just shifted the whole relationship with the women. When we went to see women in their homes, we were on the same ground - all of us. But, Nola played into this thing of "I am the midwife, I am in control and you are just the little lowly woman down there."*

When we listen to Elise's experience with Nola, we recognize how pervasive a hierarchical structure may be in preventing the creation of a spirit of trust and cooperation. Women chose Nola, not necessarily because she was a good midwife, someone that they liked, trusted, felt comfortable with, but because she was the "best," the most experienced, the mother of all mothers.

Yet, the intense competition such as experienced by Elise ultimately destroys the community. In the end, it was Elise who no longer trusted Nola. In situations where there is no trust, with no sharing of responsibility between midwife and woman, nor the recognition of one another's strengths and limits, the community is effected. There is little room for friendship between midwife and woman or between midwives themselves.

In Starhawk's novel *The fifth sacred thing* (1993) she described a community of equality, where each member of the community brings their particular strengths to the betterment of the community. Each member has their particular place within the community and is valued for their contribution to the community as a whole. The central character, Madrone is a midwife. It is clear that Madrone is an honoured member of her community. Her knowledge and skills in birthing and healing are highly valued. And yet, it is also clear that Madrone has no greater "status" in her community than any other member. Imagine living within a community where each member is highly valued by all other members, where a balance has been struck between the needs of the individual and the needs of the community as a whole. Imagine being recognized for your contribution to the community, and not for the status attached to a particular job, occupation, or career. While the community in this novel is fiction, it has similarities to the midwifery community. The midwives bring important knowledge, skills and "gifts" into the community. Yet, they are quick to re-place the credit for the birthing work to the woman, her family, her supports. Some midwives say that their greatest gift is for the woman to feel like she "did it on her own." Not in isolation, not without support, but that the woman recognizes her own strength and her "gifts" in birthing.

Kathleen - Doing it on her own

> *Melodie had one day of having what she kind of called spasms. She didn't really define it as labour. We talked a few times that day. She phoned the next morning, she had slept and now she was having contractions 5 minutes apart lasting 30 seconds. I told her this was normal and to rest, to phone if she needed to and I would check back with her. I wanted to give her the support over the phone and I wanted to*

reassure her that it was fine if she didn't need me there to be holding her hand. I gave her some ideas of things to do when I wasn't there. She had enough knowledge too, from the classes and from the phone calls of what she could do to help herself. And, I like that. It makes me feel like I have done my job because she has found enough power in herself to handle birth, to handle the labour basically on her own. Some husbands are real supportive and I know some women get that support from their husbands but this man was actually at work that day so I knew Melodie did a lot of it on her own.

How often do we have this experience - of feeling fully supported, yet empowered, of being fully credited for our work, even when others have played an important role? Isn't it most often experienced within relationships where we feel safe, and close, and non-competitive? With family or friends? Perhaps this is a significant part of why so many women sense a friendship with their midwife. Who else but a friend or family member would marvel in your ability and respond to your thanks by saying *"thank you for inviting me to your birth, you are the one who did all the work"*? Women like Theresa recognize this friendship with their midwife is different from their social friends. For many of the women, the friendship is restricted to the context of pregnancy and birthing, lasting only as long as the woman remains part of the midwifery community. This does not make it any less of a friendship, however, it is a "special" friendship with it's own rules and boundaries.

Midwives are cautious about friendship with women in their practices. Midwives come into contact with many many women. Last year, my partner and I provided care for 85 women. How much do I have to give? Am I in danger of giving too much or too often? Anne and Jacqueline tried to become and remain friends with most of the women when they first started to practice midwifery, but soon changed their approach as their practises grew. The realities of maintaining close personal relationships with an ever increasing number of women can quickly become overwhelming. Anne spoke of the difficulty of trying to maintain friendships with the women. *"There was an awful lot of onus on me to keep the friendships active. A number of years ago, I came very close to*

burning out because I couldn't cope with the demands on my personal space and time." Midwives are particularly concerned about the women who do not seem to be able to let go of the relationship they developed during their pregnancy and birth.

Elise - The stalker

> *We've had the experience over the years where we've been almost stalked by some clients. I have one who lives three blocks away! A stalker who is just three blocks away! I'll go to the post office and she'll find me. She follows me everywhere and she wants to come over and have tea with me and makes me cookies and makes me meals and be my best friend.*

Listening to Elise's story or to Anne's concerns about keeping the friendships going, we find ourselves questioning whether these relationships were ever friendships. A relationship where one person must assume all the responsibility for making the phone calls, arranging the meetings, and keeping in touch or where one person does not want the attentions of the other does not feel like a friendship. Perhaps the midwife's role in arranging visits and calling to see how things are going when she was providing care for the woman set a pattern where this became an expectation beyond the context of caregiving. Perhaps the woman experienced such an environment of care with the midwife that she will do anything to extend that experience. Whether midwife or woman initiated, these relationships take on a form of dependancy. Perhaps the midwife needs the woman to stay in touch, to keep her feeling needed, or to keep her feeling some importance. Perhaps the woman needs the caring, the nurturing, or the affirmation that she received with her midwife and perhaps is not receiving anywhere else in her life. Friendship is not an end in itself, is not a social contract. While friendships can be used "instrumentally," in other words, friends do provide services for one another such as babysitting children or typing a paper, friendship cannot be defined by the services. Each individual should freely give to the other, not because they expect something in return, but because there is a comfort or joy in giving to the other (Hutter, 1978). However,

there must be a sense of reciprocity in giving and receiving. The burdens of "debt" when the giving in a friendship is exclusively in one direction quickly become heavy and may ultimately destroy the friendship. Laurel considers Holly to be her friend. She feels comfortable talking to her about concerns beyond the pregnancy and birth and appreciates that Holly will share information about her own life. She expects Holly to be a midwife to her at the birth experience, making decisions and taking responsibility as required. She recognizes that Holly is a busy woman with a busy life, and she respects that busy-ness. Laurel explained *"in a funny way, I take care of my midwife. I have a vested interest in her wellbeing. It's a symbiotic relationship."*

Friendships between women and midwives are acceptable in the midwifery community. Midwives know the difference between women who are "just" experiencing midwifery care and women who have become friends. Anne explained *"when the woman is a friend, it becomes a two way thing. I can phone her for advice and she can phone me for advice. The support goes both ways, it's a wonderful thing."* When I reflect on my experiences as a midwife, I recognize the friendships that extend beyond the birth experience are rare. It is often difficult to pinpoint what actually triggered the friendship. Sometimes it is nearly immediate, and others, it occurs over time. Sometimes it develops because of the nature of the birth experience itself - a particular intensity, joy, or difficulty which brought us to a place of sharing and mutual support. At times, the label of friend comes as a surprise to me. I remember doing a prenatal home visit with a woman who was 16 and expecting her first baby. She took me on a tour of the house, proudly showing me her bedroom - still a teenager's room with posters and toys decorating the walls and shelves, yet becoming a mother's room with a cradle by her single bed and baby clothes in the closet. We also visited her parent's room with the Jacuzzi tub, perhaps her choice of birthplace. When we were back in the family room, her mother spoke of the differences in her own experience. She was also 16 when she had her first baby. She spoke

of shame and terror, especially at the birth. She said that her daughter was so lucky because I was now her friend.

In addition to the social environment, the individual's own personal boundaries may influence her choice to enter into a friendship with an other. The midwife's sense of herself, her roles and her relationship with a particular woman, and her sense of the space that she has available within her personal boundaries are considerations when making this choice. Midwives too, recognize that this is a "special" form of friendship, recognizing that these friendships often wane as the women moves further away from the birth and as the midwife takes on more clients. Unlike other healthcare professionals who will not take on friends as clients, midwives are comfortable with this possibility. Jacqueline says that having a client who was first a friend is even better than a client who was not, she has a trust and a bond right from the outset. Anne challenged the professional taboo against providing care for friends. She said *"my doctor says she won't catch a friend's baby in case something goes wrong. We don't look at it like that. We turn that around and say we are coming together as friends and we are sharing this entire experience."*

Perhaps it is the recognition that her personal space has room for many relationships, the addition of one more friend need not mean less space for other important relationships that opens the possibility of friendship. I think of the richness that my life has developed through my association with all the women I have encountered as a midwife. The things that I have learned about women, birthing, families, and myself have come from being open to developing close relationships rather than from protecting myself from becoming too close or too involved. Perhaps the addition of each new friend helps to create space for others. Horst Hutter (1978) says that we should be able to see ourselves reflected in a friend. Each new friendship brings us a deeper understanding of ourselves, the multidimensional sense of *who I am*.

Friendship - a dangerous relation?

When I speak of friendship to other health care professionals, I am often met with skepticism, doubt, or warnings. Friendship is not a possibility within their communities. Some tell me that midwives are taking advantage of women in a vulnerable time if they try to create friendships with them. Others tell me that midwives are belittling the concept of friendship. It must never happen in a professional relationship, as there is always hierarchy and imbalance. Others warn me that midwives are putting themselves in jeopardy if they develop friendships with their clients, that they will become governed by emotions rather than reason, that midwives will make bad decisions, give bad care, and ultimately face liability.

Many professional bodies have strong positions about mixing personal and professional relations. For example, the Alberta Association of Registered Nurses (AARN) draft document on professional boundaries (1996) states:

> "One common form of boundary violation is the dual role, where the professional assumes an additional role in the life of the client, such as that of a friend. The consequences for crossing boundaries can be traumatic for both the patient and the nurse. (P.22) "Decisions to cross professional boundaries should be deliberate, time-limited choices which clearly contribute to clients' health outcomes in an acceptable manner. Boundary violations are never acceptable." (P. 25)

We are often warned that professional relationships can never, should never become personal relationships. The warnings are important ones. When the consumer/client/patient comes to the professional, she may be in a very vulnerable position, one in which the privileges and power of the professional can result in extreme imbalances leading to coercion. We seldom enter personal relationships where it is considered to be completely acceptable for one person to be able to ask about the most intimate details of the other's life and yet not be expected to share any intimate details about their own life. We seldom enter personal relationships where it is considered to be completely acceptable for one person to tell the other exactly what to do or what will be done to them. It is

difficult to imagine a friendship where this imbalance of knowledge and power are the norms of friendship and not the characteristics of a friendship gone wrong.

Keeping the relationship between *I*, the professional and *you*, the recipient of care very formal and professional makes the boundaries between individuals clear. The caregiver knows that there is a limit to appropriate discussion topics, to the appropriate actions or touches, or to the appropriate use of paternalism. The client knows that there is a safeness within this professional boundary. There is never the worry that the wrong questions will be asked, that any advantage will be taken, that her confidences will be broken. Kathleen's greatest concern about developing friendships with her clients is that she may inadvertently break confidences when speaking casually about her self and her work. When we read newspaper reports of healthcare professionals engaging in sexual activities with their clients/patients, we know it is wrong. We know that the professional has crossed a boundary in a way that is no longer appropriate and we know that it is important to have the safeguards and warnings.

The Alberta Association of Registered Nurses (1996) defines professional boundaries as "those lines which separate therapeutic behaviour of the registered nurse from behaviour which, whether well intentioned or not, could detract from achievable health outcomes for patients and clients receiving nursing care" (p.7). Using this type of definition, the "proper" caregiver-client relationship is a professional relationship where the therapeutic behaviour on the part of the caregiver is the overall goal. The responsibility for maintaining the boundaries rests with the caregiver, "it is the responsibility of the registered nurse to maintain both personal and professional boundaries and to help the patient maintain his or her own limits. When patients cannot do this, the nurse must provide the boundaries" (p.7).

While these directives have merit, they evoke questions about how they are to be implemented in practice. How do we determine what are appropriate boundaries? How do we determine the limitations to what is appropriate and not, what is professional and not? It is difficult to envision boundaries that are not set

through collaboration between the midwife and the woman. While professional boundaries are dictated by professional regulations and standards, the initial and ongoing discussions between midwife and woman clarify and personalize these boundaries. It is my responsibility as a midwife to explain to the woman what the limits are on my abilities, my services, my scope of "therapeutic activities." And, the woman needs to be clear with me about her expectations, her limitations, what she sees as overstepping the professional boundary. If these are set by the midwife alone, she will never be sure if the boundaries are too close or too distant in the eyes of the woman. Heather struggled with her expectations of professionalism from her midwives.

Heather - Anti-establishment, political treatments

> *Even though I had 24 hours of pretty hard back labour, the two midwives just made me feel very very comfortable physically and emotionally. When it came to having my second baby 2 years later, there was no doubt in my mind that I wanted specifically those two midwives. I felt that they knew me and my body and what I would do. I had a sense of their feel and their touch and their reactions as well, so certainly the second time around was like with friends. The first time around, the physical support they gave me with leaning into my back pressure points with the back labour bonded us a lot. I laboured in my cast iron tub upstairs with that first one and Debra had her hand on my shoulder anchoring me for a long time and I just felt for months afterwards the impression of her hand. After that first birth with all the back labour, I really felt I hadn't suffered at all because the midwives were there. I just felt that I would cross the street and kiss their feet. I felt in awe of what they do and their ability to be selfless about it.*
>
> *Still, I didn't feel that the midwife was quite as professional as she could have been when it came to communicating about some things like vaccinations. I understand that my midwife said in the prenatal class that they were just presenting a range of alternatives. But, it was clear by their body language that they leaned towards more anti-establishment, political treatments. And we weren't comfortable with that. I don't understand the vaccination issue. When you look at it statistically, it is so much better to be vaccinated than not, even though there are those people who have severe reaction, it shouldn't stop anyone from vaccinating.*

Heather's midwives used a strategy commonly encouraged in professional practice. They maintained a strong boundary between personal opinions and professional advice by presenting information about a range of alternatives about immunization without acknowledging their personal preferences or biases. We are taught that our best decisions as professionals are the objective ones, the ones that are not somehow clouded by our personal biases or emotions. But it is impossible to eliminate our preferences or biases from all forms of communication. Heather noted that her midwives had a bias, not because they stated that bias, but because it was evident to her in their non-verbal communication.

These strong professional boundaries may contribute to discomfort for both midwife and woman. Rather than resulting in a sense of working together, boundaries may alienate one from the other, perhaps even contributing to a sense of conflict. When someone asks us to consider an alternative to our personal views, we often find ourselves questioning their motives. In situations where we know little of the other's beliefs and values, and sense that the other knows little of us, our questioning may turn to suspicion. *"Why is the midwife suggesting that we question the immunization policies?"* We recognize the dilemmas encountered when attempting to work within strict professional boundaries when hearing Heather's story about her midwives' approach to immunization. At her birth, Heather experienced a very close relation with her midwives. Perhaps it was this same closeness that she wanted at the class about immunization. She needed to know clearly her midwives' views. Perhaps Heather believed that she had similar preferences or biases to her midwives. After all, we are often attracted to, become close to, or admire an other because of a sense of similarity. We may even say that we "think alike." It is not difficult to imagine a sense of discomfort or confusion when a difference is discovered and yet there is not an openness about that difference.

While the guidelines about professional boundaries are important, it is also critical to remain aware of the potential harms of maintaining strict, universal

boundaries. The guidelines are present because we recognize that there is a power differential between professional and client that makes the client vulnerable. However, if we are not vigilant about our use of boundaries, we do precisely what the guidelines are meant to prevent. Boundaries that are primarily under the control of the professional result in a distancing, a depersonalization, and an objectification of the recipient of care and of the professional.

Another purpose of professional boundaries is to ensure that the personal feelings of the professional toward the person receiving care does not affect the quality of the care received. Not only should the professional give the same type, amount, and standard of care to all individuals regardless of liking or not liking the individual, the professional should be "above" liking or not liking. Perhaps this lack of personal opinion comes from some super-human qualities bestowed upon the professional, perhaps from an approach so distant that the professional is unable to really know enough to like or not like. Rather than putting aside or denying personal opinions about an other, midwives are attentive to their personal feelings about the woman. Recall how Brett said *"you have to like her."* Many midwives will offer referral to another midwife when they feel that there is not a good match between midwife and woman. When there is not a clear sense of liking or not liking, just a distance between midwife and woman, the midwife continues holding a door open for a closeness to form. Jacqueline said *"I always find ways to love these women, even the nasty ones, just by taking the time to get to know them."* Occasionally, the midwife finds herself in a situation where she does not like the woman.

Andrea - Pushing buttons

> *It was about 1 in the morning when Monica phoned to say that Shelley thought she was in labour AGAIN. She had already been there for two false alarms. Monica says she is not expecting a baby tonight and that it is getting hard to agree to go out in the bad weather when she doesn't even really like this woman any more. Maybe Shelley pushes a lot of buttons for Monica. In a lot of ways, they are very alike - strong willed, eldest daughters! But, Shelley and her partner Jeremy are very traditional in their relationship and belong to a fundamentalist church. Shelley has a bunch of friends staying at her tiny house to be with her for*

the birth. Some of the friends are young and thoughtless, doing things like staying up and playing music when Monica tried to sleep there one night when Shelley was in false labour.

When we arrived at the house, Shelley is sitting on her bed chatting with her friends. This does not look like active labour. After about an hour, Shelley decides she wants to try lying down for a while. So far Monica has barely said a word to her. Before Shelley lies down, Monica wants to examine her to see what is going on. When Monica comes out of the room, she shakes her head at me and says "I knew it!" A couple of hours later, Shelley comes out of the bedroom and says she is still having contractions but she has slept. Monica jumps up and starts packing up her equipment. She says that she doesn't see any point in waiting around there. Later that day, Monica told me that Jeremy had called her to say that he and Shelley had decided to have the baby at their local hospital. I guess Shelley knows that Monica doesn't like her any more.

Working with women she does not like is a serious dilemma for the midwife. Joan Liaschenko (1994) says that this "not liking" is not a trivial situation like not liking french fries, rather it refers to "the difficulty in establishing and maintaining a relationship in the face of patients who evoke strong negative emotions" (p.83). The midwife knows that revealing strong negative emotions can be hurtful to the woman. Yet, it may be difficult to conceal them. Strong emotions can bubble up and spill into our everyday words and actions. In Andrea's story, Monica has not told Shelley that she does not like her, and yet we hear those strong emotions in *"I knew it!"* The midwife may be able to find ways to work through those negative emotions as Jacqueline suggested in finding ways to love each woman. However, the recognition of not liking can come at a critical time when there may be few opportunities to build or rebuild the connection between woman and midwife. Unless the midwife is able to find ways of keeping those emotions locked up, for example, having the backup midwife take on most of the caregiving activities, the woman is sure to sense them.

In this midwifery community, professional boundaries are not distinct and rigid. The boundaries between woman and midwife are developed together, perhaps with one occasionally taking a lead. At times the boundaries blur,

particularly in situations where the midwife and woman are most close and most need to rely on one another. Stories such as Alice's experience of "hearing" Margaret telling her that her baby needed to come out speak of this blurring of boundaries. These moveable, personalized boundaries allow for a range of relationships dependant on the woman, the midwife, and the particulars of the situation. Lorraine Code (1991) suggests that friendships are a good model for moral responsibility. Friendships are based on trust, mutual respect for the individuality of an other, and a "balance between separateness and interdependence" (p. 95). Caregiving situations where friendship exists are strengthened by the friendship. The responsibilities of decision making remain shared between woman and midwife. Friendship invites us to "take our friends seriously, and to take seriously what our friends care about" (Friedman, 1993, p.192). Madeleine explained: *"When I find myself very deep in a relationship with a woman, it challenges me on a very emotional level. I can get really angry. I can cry. I can be intensely overwhelmed with happiness. And I know that I have to be prepared for the intense grief and sense of loss if something goes wrong."* While friendships are acceptable and even in some cases desirable, it is not a condition of midwifery care that each woman become a friend with her midwife. These relationships are too personal and too unique to be used as a therapeutic technique.

Making Time, Taking Time

I often hear that the reason why most healthcare providers cannot provide "personalized" care is that they just don't have the time. No time to get to know the individual, no time to establish relationships, and no time to do all the tasks required of them. Time requirements are spiralling out of control. With cutbacks in healthcare, the demands on our time seem to grow and grow, most often at the cost of providing good care. The technologies that promised to free up time take up more and more of our time.

As midwives interface with other healthcare professionals, we are often told that we have been spoiled. We have small practises with women who are

motivated to spend time with us. Our small practises allow us to book plenty of time for each visit. And, we have 9 months to get to know one another. Marnie Robb (1986) suggests that time is an essential aspect to the development of friendship. What may begin as an attraction to or interest in an other may grow into a friendship if enough time is available. Kathleen often sees her relationship with women evolve throughout the pregnancy and birth. She can tell if she has developed a deep relationship with women if there is an easiness and freeness at the postpartum visits. She said *" When I go to someone's house postpartum and I feel like I'm visiting a friend, I know I've done a good job."*

And yet, deep personal relationships can develop in very little time. I recall situations with women where something immediate occurred - within the first moments of meeting, I have a sense of closeness, of attachment, and of commitment. I met Nadine one morning three years ago while she was waiting to see my partner for the first time. We sat and chatted in the five or ten minutes while she waited. What was it about those few moments that began our friendship? Perhaps it was Nadine's readiness to connect with me. Perhaps it was a familiarity that we both experienced, recognizing something of ourselves in each other. Perhaps it was the tears that Nadine shed as she told me a small anecdote, an intimate moment, from her first birth experience. I also recall situations where even after a full nine months of pregnancy, I feel no more close to the woman than I did at the first meeting.

It is usually in the last two months that I get to know most women very well. We meet frequently at prenatal classes, visits, and home visits. Phone calls are more common at this time as well. Sometimes these are little questions - perhaps a test *"how long it will take Susan to answer her pager?"* Sometimes they are big questions, too big to wait for the next visit. And sometimes, the call is just to talk, to connect, to hear that voice again. As the woman's due date nears, I find myself thinking of her frequently. Our visits are once a week now. Words come easily. We may talk about the impending birth: when to call, contingency plans, or the "what-ifs." Often we talk of discoveries: a bargain crib,

a great nursing bra, a friend who had a homebirth but kept the secret. Sometimes we talk of doubts and fears. *Can I do this? Is this the right decision? I'll die of embarrassment if I shit during the birth.* Sometimes we joke and tease one another, perhaps lightening the weight of this impending event, easing up the fears and tensions. Between visits, I often find myself mentally rehearsing a particular woman's labour and birth. *When might she call? Is she a day labourer, or will this occur at night? Will she be early or late? Will she call at the first sign of labour or wait until later when she is "sure" or when it seems a civil hour of day? What route will I take?* I listen faithfully to the road closures in case I need to plan an alternate route. As due dates approach, each time the phone rings, I wonder if this call will be the one that announces that labour has started. In my sleep, I hear imaginary calls that cause me to jump up only to realize this night sound is not my phone. I am on alert.

Letty Cottin Pogrebin (1987) suggests that in earlier days, friendships were used as a haven from the stresses of everyday life. As social structures have changed, friendship can now be a source of stress, just one more thing to try to fit into a busy life. Rather than relaxing into the enjoyment of a friendship we may worry about what others think about our choice of friends, we may bring the competitive elements of other aspects of our lives into our friendships. As work and professional life take on more and more of our lives, there is little time for social relations outside of work and family. Perhaps the context of midwifery care itself creates an atmosphere that is conducive to the development of friendship. To begin with, women are expected to attend prenatal care. The time spent with the midwife is considered to be a necessity and not a luxury that competes with work and family time. Employers often provide time off for healthcare appointments. Not only does the midwife give the woman time but the woman is able to take time. Often we put off our social commitments until everything is done. And it never is. Our friends can go on the back burner until our work is done. After all, they are friends and will understand. The woman cannot put off her visits with her midwife. Her midwifery care has an immediate

priority. The visit itself is comfortable, relaxed, not rushed. For many women, this visit is a "haven from stress," a place where she can ask her questions and know that she will not be criticized for her choices of seeking midwifery care or having a homebirth. And her midwife is friendly. What better atmosphere for friendship to take root.

The linear time of midwifery care, 9 months of pregnancy, the birth and then 6 weeks afterwards can also act as a barrier to the development of deep relationships. This is a very intense "year." But once the year is over, the intensity is gone, the reason to see the midwife is finished. The woman may no longer feel that she has a legitimate reason to visit her midwife, except perhaps to drop in to show off her baby. Many women speak of the last postpartum visit as a bittersweet experience. For some, this is like moving day or the last day at university. Our time together for this purpose in our lives is over. It is time to move on. Jane said *"after my last visit with Paula, I went home and cried because I thought 'I'm not going to get to see these people again.' It was a devastating feeling."* Jacqueline said *"some women have midwife withdrawal and I tell them that we have it too. We share a really heavy experience with the woman that I do feel as close as friends at the end, even if I am never going to see her again."*

When the midwife and woman do get together again, the time between visits, or the time between pregnancies seems to melt away. Re-entering the midwifery community, becoming reconnected with the tone attunes the woman to the midwife and the midwife to the woman. Perri commented *"I can see a great value in having repeat clients because you've done all the work together once and that makes the relationship great."* For the woman, her birth is a part of her whole life story. To some extent, the midwife stays a piece of that story forever. While some midwives say that they see a really great birth as one where the woman can say 10 years later that she had a wonderful birth experience and oh, yes, there was a midwife there, but I can't really remember her, the reality is that when we have a really wonderful experience, we do remember all of the details.

Patricia said *"I don't think about my midwives all of the time, but it's like they're always there. So even if I don't see them for months and months, I can make that first phone call and it's all back to me as though I never left the group."* Camille said *"each time I meet my midwives, there is a togetherness again for me. Even if we didn't talk about birth, there is an instant kind of closeness, a knowing and comfort. It's a kind of friendship that is knowing somebody - knowing what they'll cry about, being able to cry about it with each other."*

A Mother's Touch

One of the most precious moments after the birth is when we help the woman bathe, sometimes a sponge bath, sometimes in the tub or the shower. As she gets out of bed, we walk along side, watching for wobbly knees, holding a pad between her legs to preserve the carpet on the trip to the bathroom. She lowers herself into the tub of warm water. Gingerly dipping, testing. We all feel her muscles and aches relax. Some just sit while we wash, others busily scrub. Many bring the baby into the tub. Such a wonderful picture: the woman discovering her baby all unwrapped, floating between her legs, almost as though still inside. Her hands now holding the baby, no longer her uterus and pelvis. Somehow the baby finds her way to the breast, so often the first good feed, all in water, warmth, relaxing. The blood dyes the water pink.

One of us makes the bed. Somehow a loving ritual, creating the nest for the woman and her family. Taking off the bloody sheets and plastic covers. Picking off blood clots and soaking sheets in cold water in the washer. Acts my friends cannot understand. *"We escaped such degrading tasks long ago in nursing."* Rituals: caring for the home, caring for the woman.

When the woman is ready one of us takes the baby. My favourite job is helping the woman. Holding open the big towel warm from the oven or drier. Drying her breasts not yet full, but already experienced in the tug of nursing. Drying her soft abdomen, once firmly full of baby, now velvety, mushy. Carefully drying her perineum, still tender from the birth. Catching the rivers of blood as it runs down her legs. Drying her mottled legs. Helping her with the warm shirt,

pad and panties. Then usually back to bed: her place, her spot, her side, her sheets, her pillows, her covers, her smells. For a sleep, a snack, phone calls, a party, lots of hugs.

Many women speak of feeling so nurtured, mothered, taken care of by their midwives. These simple acts of bathing, dressing, tucking in are enormously touching to women who have seldom experienced such attention since early childhood. Perhaps these acts are only this touching, only this comforting because they happen at the end of the birth. Any sooner in the relationship, these acts may have felt demeaning or embarrassing. Perhaps these acts are touching because they are needed at the time. There is a rightness to them. Chantal recalled *"when I was pushing, I pushed out some excrement and Rose wiped it away. I was not embarrassed, Rose didn't make me feel like I was doing anything awful."* Alice said *"Margaret and Bronwen took care of me. They bathed me and cleaned up the blood on the floor and cleaned up the dishes. I felt really taken care of and that made the bond deeper for me."*

Midwives are uncomfortable to hear their work referred to as mothering. Anne said *"I'm definitely not their mother. I have my own children, I don't need to mother anybody else."* Midwives worry that being a mother to the woman means that she becomes too dependant upon the midwife. Many midwives and women found their way to midwifery as an alternative to the paternalism in the healthcare system. Barbara Katz Rothman (1989) calls midwifery "feminist praxis." Midwives are not merely a more motherly, kinder obstetrician: Midwives work from a different knowledge base, a different intersubjective stance. Their "mothering" activities are not for the purpose of creating dependancies, maintaining relations of power or objectifying the woman's experiences. Rather, these come from *this midwife's* commitment to *this woman*. Bathing after the birth is an act of love and kindness. It is not a way to make the woman feel like a child incapable of caring for this new baby. It is not an attempt to expose the woman and her body to further vulnerabilities. It is not a part of the clean-up

routine: clean the floor, clean the instruments, and clean the woman. Bathing after the birth is not a routine.

This sense of the mother's touch is heard throughout the women's and midwives' stories. Recall Camille's appreciation that she did not need to ask Gwen for things like lighting the candles. Gwen somehow understood that this might be something that she wanted. Kathleen told me a story of giving a new client a hug as she finished her visit. She said that she was looking forward to providing care to this woman, that she felt that a very good "client-mother" relationship would develop. We laughed about her "mistake." She had meant to say "client-midwife." But she went on to say *"I think I do mother sometimes, but I hope I do it appropriately. I do it in the sense of warmth and caring, being there when I'm needed, guiding and supporting, and helping them to find their own power. But not in the sense of dependence."* When Claire said *"I felt so cared for, I felt totally looked after"* as she told the story of her birth, we do not hear dependence. We hear commitment, respect, and honour.

Part of the family

When a midwife enters into the life of a woman and her family, she does so as a very special guest. She comes into the woman's home and into her life at a time that is a celebration of family and of the woman. She brings her expertise, her knowledge, and her skills. And yet, she also brings a recognition that this is the woman's experience and the family's experience that she has been invited to enter. She does not enter because of culturally sanctioned routines of the public health nurse. When she enters the woman's home and her life, the midwife comes into the most private places. This is not a front parlour visit, the midwife may sit on the couple's bed with them, may stand by the toilet as the woman voids, may root through dirty laundry searching for one more wash cloth, or may discover that the oven has not been cleaned for years.

How often do we have guests in our home, in our lives when we feel comfortable enough to be ourselves? When we do not feel that we have to clean up, make our appearances perfect? This comfort generally most often comes

with our closest friends or our dearest family who we know will not judge us if our lives are in chaos. Alice is relaxed when Margaret visits after her birth. She compared those visits to those of other well-meaning friends where she feels she needs to entertain. After those visits, she is more exhausted and strained even though these friends hoped to come to give her a little break. On the other hand she said that Margaret would come and just make herself a cup of tea. She recalled one visit where Margaret arrived and her sons Mark and Thomas were hungry . She said *"she made them about 8 pieces of toast. They are very picky and she didn't do it right and she had to redo it and cut the crust off and put the jam on this way. And she was relaxed about it, and I felt I could actually rest."*

The first time the midwife came to her home, Jane did not feel comfortable. She felt that she needed to have the house spotless and her legs shaved before she called the midwife for her labour. But, by her second birth, she felt comfortable to be herself. She said *"It's not a first date situation. You're completely naked, which is scary at the best of times. You are hollering when something really hurts. You can cry or burp in front of the midwives. There is way too much letting go that you can only do with a close friend."*

Brett said that it is often the woman being herself, rather than putting on a front of the perfect woman, the perfect homemaker, the perfect mother that draws her even closer to women. She described a woman who has become a close friend. *"What really connected us was that she showed up one day for a prenatal visit and she had forgotten to put her shorts on. She had a nightshirt on. She said 'I got up from my nap, I was late for my visit and I grabbed the kids and jumped into the car and I forgot to put my shorts on.' And I thought 'you're so human, I want to keep you.'"* The midwife shares a very significant experience with the woman and her family. She sees them at their best and at their worst and still she stays with them.

Kathleen - One of the family

> *I remember one man, a father, who I had a lot of trouble with before the birth. He didn't seem to be a very nice guy. I didn't like the way he spoke to or treated his children. His manner was always kind of*

gruff. He seemed to be so macho and angry. But after the birth, he went over to the dresser in the bedroom and he took this pin and he pinned it on my lapel and he said "this is our clan pin and you are now one of the family." I was so touched.

The midwife is there throughout a period of growth for the woman and the family. Perhaps it is the midwife's willingness to accompany them on this journey rather than direct the journey that opens the possibility to be such a special guest, just like one of the family. Rachel said *"I form a permanent bond with the women and often the whole family. I guess it is from going through that heavy space together, seeing each other through it and for me, having the honour of being there."*

Angels in the house

When I first met with Camille, she asked if I had been to any births recently. I told her that we had actually been quite busy and had missed a lot of sleep, couldn't she tell by my huge dark circles under my eyes? She said *"angels don't get dark circles."* Based on her experience, Camille thinks that all midwives must be angels. Alice too, compared her midwives to angels. She said *"I felt like there were angels in my home. I felt very comfortable being me with my faults and my health and my woundedness. I love Margaret and Bronwen and I feel love from both of them."* I puzzled over this comparison with angels. Do midwives present themselves as being somehow super-human? I recalled being at Jill's birth where her partner Alan kept calling me batwoman. I thought it was because it was during the night. When the card attached to the flowers they gave me afterwards was also addressed to batwoman, I asked why this nick-name. He told me about an episode of *Seinfelt* where one character told a story of performing several super-human feats in a crisis and another character responded to the story saying *"wow, you're batman."* I recognize these as super-human feats by a very human character.

Stories and myths of angels are known in nearly every culture, in nearly every religion. Angels are messengers, protectors, guides (Burnham, 1990). Angel stories call to a common understanding that something special has

occurred. And yet, we also sense an ordinariness, a humanness to angels. Perhaps the "angel" is an understanding that comes from within the woman. An insight of herself, of others, of the possibilities for how two people can be together. Camille says that her home is more complete for having had a midwife in it. Inviting a midwife into her home, into her life helped her to build a bridge between herself and her experiences. Even though she has moved to a new house since her birth and no midwife has actually stepped foot in her house, she says *"I would say there has definitely been a midwife in my home. My house has the spirit of a midwife in it. Gwen knew that it was important for me to have my placenta. So, my placenta is in my freezer, it holds the spirit of a midwife."*

Friends, sisters, mothers and angels. All these relational possibilities exist between midwife and woman. Rather than viewing professional and personal relations as mutually exclusive categories, we see in the stories of midwives and women the rightness to their co-existence. The responsibilities of all forms of relations, whether primarily personal or primarily professional are not taken lightly. The expectations for safe midwifery care are felt by both woman and midwife: the expectations for safeness, for respect, and for confidentiality within a personal relationship. These forms of relations become intertwined strengthening one another.

Chapter Seven

Awakening to Our Women-Selves

> *It definitely made a difference that my midwife was a woman. I don't think that a midwife has to have a baby to be a midwife because I think that there is something that brings women to that profession. It is a birth of herself as a woman. (Camille)*

Each woman clearly said that she felt that her midwife had to be a woman. Some thought that some very special men might be able to be midwives, but most clearly dismissed the possibility of a man midwife. This is women's work. What is it about being a woman that results in this strong reaction? Is it only because each woman did have a woman midwife that she is only able to be open to that possibility? Is it something political that the midwives themselves encourage? Or is there something in the experience of being a *woman with woman* that calls to women in a very deep way?

Perhaps this sense of *woman with woman* is a reflection of the earlier themes: trust, the birth experience, friendship. Throughout the discussion of these themes, the experience of being a woman, giving care to or receiving care from another woman resonates. Midwives like Madeleine compared the kinds of relationships that she was able to experience in midwifery with those she experienced in male dominated jobs. She spoke of woman - to - woman relationships that had depth, were personal and intimate. Women and midwives spoke of a special understanding of the birth experience that comes from a particular woman's point of view. Camille spoke of others - both male and female - who *"didn't have a clue"* what her birth experience was about. The reciprocal nature of the trust developed between women and their midwives is in part built on a safeness perceived in being together as women. And yet, there seems to be a "more-ness" to this experience of *woman with woman* that is not addressed in the earlier themes. What is it like to be *with woman* in a way that calls to a rightness of this match?

Awakening to the mysteries of the woman's body

Elizabeth - Common Ground

> *I bring the common ground of being a woman into my practice - knowing how touch feels, knowing when the permission has not been given, understanding the whole cycle of birth and having been through that and menstruation. So I feel that there is a common ground there - an opening. If I were looking for a midwife, it would be important for me that she is a woman - there is a common ground of how we live out our lives and experience our emotions and experience our bodies and are able to celebrate one another.*

Perhaps the rightness of *woman - with - woman* is in the common ground of living in a woman's body. Virginia Beane Rutter (1994) suggests that woman - to - woman therapy is influenced by the experience of *two alike bodies* working together. What is this like: the experience of *two alike bodies* giving and receiving care? Is it only that the midwife and woman are female? Perhaps not. Camille described an experience with a young female nurse who was not patient with her pain, who did not understand her sorrow about her cesarean section. Other women speak of their disappointments with experiences with female physicians. The genetic alikeness, two X chromosomes is not all that needs to be present to be *two alike bodies*. Perhaps the sense of "alikeness" is at a more complex level than gender alone. Most midwives have experienced pregnancy and birth. Perhaps this is the common ground. Some women (e.g. Alice, Claire and Cynthia) did feel a great affinity to their midwife because she had experienced childbirth. However, many said that the actual experience of childbirth is not necessary for their midwife to be a good midwife. As Camille noted, it is not giving birth to a baby that ultimately brings a midwife to that work, it is the birth of herself as a woman. The alikeness is in this birth - birth of woman.

Journey into midwifery - the birth of herself as a woman

Perhaps an understanding of *two alike bodies* can begin with the journey into midwifery. As I reflect on the stories that midwives told of this journey, I hear a shift in knowledge, in interest, and in focus related to women. As I think of my

own journey, I can remember a constant interest in babies and a curiosity about pregnancy. My first exposure to childbirth as a nursing student, however, was frightening. The realities of pregnancy, birth and the postpartum period, viewing and touching the woman's body were so intense that I was overwhelmed. I recall so many mixed messages about being a woman: be a woman, don't be a woman, androgyny, hiding the knowledge and realities of menstruation, sexual freedom, choices about pregnancy, expectations to get married and have children, and expectations to focus on a career. When I started my first job as a delivery room nurse, I armed myself for the work. I learned anatomy, physiology, pathology, procedures - knowledge that gave me confidence. With time, I began to hear new stories that peaked an interest in something else, stories that called me to examine what it is to be a woman. These stories came from women who were not happy in their hospital experiences, who perhaps had cesarean sections, or perhaps had babies who did not survive. But more and more, these stories came from women who had good births by our hospital standards. A turning point for me was Margaret Atwood's media story of her birth. She was unhappy with the hospital procedures, with the approach of the staff, and with the lack of attention to her particular needs. Her birth was at my hospital. Her nurse was a friend of mine; she told me that this was a wonderful birth. Margaret Atwood's story and my friend's story of this very same birth were so different, I began to question what it was that I did as a nurse. Did I contribute to the unhappiness told by these women?

Elizabeth speaks of the common experience of the body that is an important part of her practice. Midwives do develop a detailed knowledge of the anatomy and physiology of the woman's body through their education and experience. I listened to midwives "teach" in visits, in prenatal classes, and during births. Each time, the midwife clearly explained, unravelling the mysteries of the body, telling the woman that she too can understand. Yet, the common ground, the sharing of body experiences Elizabeth speaks of are more than "textbook" understandings. And as I listened more to the "teaching" I recognized

that even in unravelling these mysteries, the emphasis was not on the superficial, "meaningless" knowledge from the texts such as stages of labour, levels of breathing for labour, or newborn weight gain patterns. While this knowledge was conveyed, it was connected to a deeper, experiential knowledge. When I looked at the midwives' bookshelves full of texts of obstetrics, midwifery, anatomy, physiology, nutrition, herbs, poetry, art, and birth stories, I recognized that there are so many ways to come to understand the woman's body.

Blythe will sometimes use her own experiences in childbirth to connect textbook knowledge to the woman's experience. One woman had many questions about episiotomy. She had her first birth with an obstetrician and received a large episiotomy. She worried about needing one again. Blythe shared her own experience of having a large episiotomy where the physician did a "husband stitch" making her healing long and painful. She said *"I told her that we had to go back to doing perineal massage to ever have intercourse. And she just exploded with an emotional outburst of anger and resentment toward her doctor. She had been directing her resentment toward her husband, she didn't know why intercourse hurt so much."* Blythe was comfortable enough in her woman's body to share these intimate experiences with another woman.

The common ground may also lead us to be cautious about our curiosities, our quest for knowledge. We have experienced the impact that purely scientific knowledge has had on our lives as women (Ehrenreich & English, 1989; Floyd, 1992; Martin, 1987). We speak to our grandmothers, our mothers, our sisters, ourselves about twilight sleep, episiotomies, formula feeding, electronic fetal monitoring, cesarean sections for breech presentations, or norplant. I recall a lecture I attended where a research team discussed their long term goal of unravelling the mystery of the onset of human labour. For a moment, I became caught in the excitement, this knowledge could be a wonderful way of preventing preterm birth, reducing the incidence of low birth weight babies and all the complications associated with this, reducing grief for families, reducing health care costs. But quickly, I began to hope that this is a

mystery that will never be completely unravelled. I saw a pandora's box. What will it mean for women? I thought of the sheep used in perinatal research. We now fully understand the mechanism of labour onset in sheep. We can control it, we can stop it, we can predict it. And I thought of what they do to the sheep (Nathanielsz, 1992). More recently I think of the lamb that was cloned from a cell on her mother's udder. Is this our future as women?

While understandings of hormones and cells and genetics are important to midwifery practice, they can be attained through scientific research without attention to the experience of "full bodied living." Other midwives also described a strong sense of being a woman, living in a woman's body and the understandings that this attention brings. Brett described her growth in understanding of women's experiences gained through midwifery:

Brett - The essence of womanhood

> *As a midwife, I spend a lot of time looking at my own issues about being a woman. I feel very proud and very honoured about being a woman. I realize that every time I go through this process of being with a woman it is deepening my sense of myself being a woman. This sense of myself gets deeper and deeper. I am a person now that I was not 20 years ago, and not only through the process of life, but from being in a situation where who I am is completely accepted and completely honoured. I wish that for every woman. I just think that we are all drawn to midwifery because we all have a deep sense of the woman within us. Being with woman is an internal thing. These are really deep things. We are not just with this physical woman who is giving birth, we are with the essence of womanhood every time.*

The journey into midwifery involves a deepening sense of comfort in being a woman, living in a woman's body. The curiosity in this journey leads to a quest for understanding what it means to be committed to women, to honour women and women's bodies, to find ways of doing the work of midwifery without reducing the work to tasks of tending to the woman's body and the baby in the woman's body. In listening to the stories told by women and midwives, in watching videos such as *Spiritual Midwifery* and *The Midwife's Story*, in looking

at women's birth pictures, we sense a strong commitment to the woman's powers in birthing. We sense love. We sense beauty.

Baubo's gift to Demeter - the power of the woman's body

Throughout time, it is in depictions of the woman's body that we gain an understanding of her strength, of her power. While male power is often depicted through their use of technologies - swords, guns and canons, woman's power is shown in her generative and nourishing capabilities. Winifred Milius Lubell (1994) tells the story of Baubo, a servant of the Greek goddess Demeter. When Demeter is mourning the loss of her daughter Persephone, Baubo is able to make her smile by pulling up her skirts and showing her vulva. Baubo reminds Demeter that women have within their bodies the powers of life, death and rebirth. For generations, the pose of Baubo with skirts raised and genitals exposed, was sacred. With time, women's place in society changed, and the Baubo pose was considered profane. Rather than representing the generative powers of women, Baubo and her "cousins" in other cultures were used to depict the dangers of women. In our society, the Baubo pose is seen as the centre fold in *Playboy* (Lubell, 1994). This is not sacred, this is profane.

In the journey to midwifery, there is an awakening to the sacred nature of women. Rachel said *"it is a really holy experience."* When we hear Christie speak of putting some of her birth pictures up on her living room wall, when we hear Alice speak of her joy in watching her birth video, we recognize that women too are awakened to the sacred in this journey. I recall attending a hospital birth in this past year where there was a sign on the elevator saying *"Attention obstetrical patients. Husbands are welcome to take photographs of the mother and baby following the delivery. Videotaping is strictly forbidden."* This woman thought she might like to have a few photographs of the birth itself, so I went to the nurses' station to ask if we could get permission. I was told that it was "disgusting" to want to photograph the birth. Permission denied. The sacred has been forgotten in our healthcare system.

Perhaps it is the awakening to the sacred that calls midwives to this work. There is a sense of something so powerful that we are called again and again to witness it. Brett said *"I really like births and I really like going to them, and I like the energy that is created at a homebirth."* Madeleine said *"it's like being able to participate in somebody else's really sacred venture in life. I get a lot out of that."* It is erotic - an experience so powerful that it calls us to "feel the power of erotic energy in one's body" (Tomm, 1995, p.67). The erotic or eros is about self love, a connection of self, mind and body, a connection of self to others. It is experienced by the woman, it is experienced by the midwife.

And yet, there is also an attraction to the grounded human or mundane nature of pregnancy and birth. These are natural processes, connecting humans to the earth. Many of the early art forms of women had no feet. Historians suggest that this represented a strong knowledge of the connection of women and nature, woman and the earth, a connection that regenerates humans and regenerates the earth (Lubell, 1994; Hall, 1980). Perhaps it is not surprising that the entry into midwifery for both midwives and women is often accompanied by a shift to less technology, less waste, fewer chemicals, or an interest in herbs. Christie said *"I've had a major change, before I took the kids to the doctor for the least little thing. Now, I'm more relaxed, if they seem happy and healthy, I don't think they need antibiotics. I'll try diet or even a homeopathic remedy first."* Claire and Cynthia prepared and consumed their placentas. Many other women buried their placentas back into the earth. Like our sister's before us, we nourish the earth with our blood (Grahn, 1993). Midwives are attentive to the connections of fertility and labour to the cycling of nature, the phases of the moon, and the changes in the weather. Urban living has disconnected our awareness of these cycles of nature. Pharmaceutical control over the cycling of our bodies: mini menstrual periods that come on command and deadened premenstrual experiences disconnects us from the nature of our bodies. And yet, the connections remain. It is no surprise that midwives are driving to births

in the middle of the worst winter weather, to the light of a full moon, or to the dancing of the northern lights (Elias &Ketcham 1995).

Many women only began noticing pregnancies once they were pregnant themselves or only commented on the cycling of another woman's body when some "irrational" behaviour might be explained as premenstrual. Her awakening brings a new curiosity not only of her own body, but of other women's experiences. The woman may have new questions to ask her mother. *"How did your labour start?" "What did you feel?" "Who was with you?"* She is curious about the other women in her prenatal class, the other women seeing her midwife. Jane said *"when Paula told me about other women's births it made me feel like we were all women and we were all in this together."* Perhaps her awakening will give her new knowledge to pass to her daughters.

Over the years, I've had an opportunity to attend births where only women are present. These "women only" experiences may have been because the male partner was out of town, was too uncomfortable to be at the birth, or because there was no male partner, perhaps this is a "single" woman, or a lesbian couple. These "women only" births give a slightly different insight into the possibilities of this awakening. All the women present are just a little freer with their bodies and their words. I recall two waterbirths where the midwife peeled down to her underwear to catch the baby. Usually, the midwife steps into the water wearing shorts and a t-shirt and usually gets completely soaked. The jokes and stories told, particularly before the labour becomes intense are ones understood by women. I am reminded of cultures where women's work in birthing continues to be celebrated. At the festival of St Domnēs in Greece, the local midwife sits on a throne wearing a necklace of fruits and vegetables. Each woman in town presents her with a gift and the old women attend her and "offer her a phallic shaped object made from a large leek or sausage to kiss" (Lubell, 1994, p.20). Then the midwife and women dance through the streets, singing songs and telling jokes that are "lewd." The men stay inside. Like the pose of Baubo, these "women only" moments are a celebration of women and their powers.

Some of the women come to midwives with a pre-existing sense of awakening to their bodies. Perhaps it is this awakening that led them to midwives. Recall that Patricia did not seek any prenatal care until very near the end of her pregnancy because she had a strong belief that her body was healthy. Aiden chose midwifery for her first birth because *"I'm very natural oriented, and seek the least intervention, the most natural things. And so that just dovetailed with midwifery."*

The approach of the midwife throughout the woman's pregnancy, birth and early mothering experiences is an invitation for the woman to participate in this awakening. The midwife focuses on the power of the woman's body, not just on the baby in her body, not just on the physical changes of pregnancy. This focus draws attention to the power and calls the woman to remain focused on her power. The immense changes described by Madeleine, the cracking open, the out-spilling of emotions come with this focus on the woman's own power. Experiencing these changes accompanied by a midwife, another woman, may intensify this knowledge. "Another woman's body mirrors her own, boundaries between them dissolve, and a merging that encompasses the totality of both bodies and auras can occur" (Bolen, 1994, p.132). We learn because we see ourselves reflected in an other, we blur our boundaries with an other, with an other of an "alike body." We hear this experience in Brett's sense of being with the essence of womanhood in her work as a midwife. We hear it as women speak of their midwives. Alice said *"Margaret is a really down to earth natural kind of woman and that really struck me. She is very alternative and comfortable with her body and I like that. I think that is how I am too."* Aiden said *"I look to Melanie as a strong woman. She's a role model. I see her strengths and I see those strengths in myself. I just need to nurture them."*

Biological determinism?

Some may have concerns about this orientation toward the power of the woman's body. For centuries, women have been defined by their generative capacity (Tomm, 1995). The challenge is in creating a sense of celebration of

the woman's embodied power without limiting women to that power. The woman's sense of her body and of her power brings about new responsibilities. She can no longer leave the authority over her body in the hands of powerful experts. She now has knowledge. She now can make choices. Recall Adele's recognition that it was her responsibility to make the decision about her cesarean section. This awakening also brings a new freedom. The mysteries of the body are more explicit to the woman, she no longer needs to rely on others to translate these for her.

The challenge is further complicated by the difficulty in putting words to this experience. Rachel is clear that her woman-ness is an important part of being a midwife, but beyond saying that she has had a homebirth, she has difficulty expressing how this is important. How do we speak of the experience of *two alike bodies* when there are no easy words? When the words that come to mind are about biological determinism, *"all women are made to give birth."* Or about sexual orientation and lesbianism. When we hear midwives like Elizabeth say *"I love women"* or women like Alice say *"I love Margaret and Bronwen"* we recognize the strength of connection of *two alike bodies*. This is about women who love to be with other women, who love women's bodies, who enjoy connection with other women on a physical level as well as an emotional and spiritual level. "Acknowledging body power is to return words to flesh and to ground our intelligence in our corporeality" (Tomm, 1995, p.84). For woman and midwife, perhaps the words are not important. Perhaps silence is important. Nor Hall (1980) points to the lack of mouths in many early art forms of women which may indicate that silence is an essential part of women's mysteries. "There is another kind of silence that is part of encountering the holy. When in the presence of something overwhelming one is silenced by the magnitude of the experience. It is mysterious because it is ineffable - there are simply no words to explain" (p.59). Jean Shinoda Bolen (1994) suggests that women may be unable to express words to describe their consciousness of their power because this consciousness is remembered primarily in her body.

In the company of women

The experience of *woman with woman* occurs in a woman's space, in the company of women. This is a space that, even if for brief moments, it is possible to escape the cultural norms of medical paternalism and gender based roles. There can be a freedom in this space to safely be a woman. To show her frailties without worrying about an other taking advantage. To show her strengths without worrying about an other being threatened. Rachel prefers to work with other midwives who are women, she believes she would be uncomfortable with a male in her practice. She explained *"I think of myself if I had a man midwife when I was pregnant. I would have felt a lot more self conscious especially when it comes to emotional things."* Aiden believes that although she has a number of very comfortable relationships with men, she would feel vulnerable with a male midwife. She said *"It would be difficult to resist the habit of falling into the 'good girl syndrome.' It would be difficult to discuss issues of sexuality or issues of concern of myself as a woman."* This company of women reminds me often of my experiences in Girl Guides. In my early teens, I thought that perhaps this separation of women and girls from the men and boys was a negative experience. I decided one summer to attend a co-ed camp rather than Guide camp. Much to my dismay, I discovered that the girls were expected to do the cooking and the cleaning, did crafts and examined nature while the boys built fires, went on canoe trips and built things. The boys were the "official" leaders and planners, and the girls did all the work. The next summer, I returned to Guide camp where all of the camp activities were open to all of us. We shared the work, perhaps doing a particular task because "it was my turn" or because "I was good at it," not because of my gender.

In the company of women, there is a peeling of the layers of our experiences of being a woman. We are invited to share our experiences with one another as ourselves, not as who we believe we must present for others' standards. We begin to recognize that much of what we have assumed as being "naturally" right, in reality comes from centuries and layers of culture, religion,

power and control. Simple acts, such as learning to test her own urine, open a door. If this is possible, what else can I do, what else can I know? Decisions such as not having a routine diagnostic ultrasound or having a homebirth bring her to question what else has she done that may not have been necessary, what else did she believe that may not have been true? Recall Cynthia's story of choosing midwifery care. She discovered in her discussion with Joanne that many of the interventions that she experienced in her first pregnancy were not necessary.

Peeling the layers can be painful. I recall my entry into this company of women. I was asked hard questions by others and by myself. I could no longer give answers that I had learned and memorized while working in the healthcare system. Rote responses from the textbooks were no longer adequate. My answers had to come from deep inside me. Why do *I* do these things? Letting go, shaking off those layers which had become comfortable and safe, like a blanket on a winter's night. This blanket could no longer protect me. Realizing that the layers are deep, that I may never in my life time completely find my way through them. The pain of peeling the layers is always present.

This pain comes to women in many ways. Recall [illegible]'s story of the woman who had sexual problems from her episiotomy. Her pain took the form of anger and resentment at her physician. Lea and Irene mourned for their lost experiences with their daughters at their hospital births after they had realized that there was no real reason for their separation. For Lea, that mourning sent her spiralling into a deep depression. Camille felt betrayed when she realized that her physicians and her therapists believed that her need to work through her birth experience was frivolous. After all, she had a healthy baby.

In some situations, the pain of peeling the layers is too much, the blanket is pulled around even tighter. Perhaps she is not quite ready to begin this process, perhaps she has a particular vulnerability that requires the blanket a little longer. Midwives find that the women who come to them for labour support only are often most unready and unwilling to enter the this process. These

women are often attracted to the idea of having someone to come to the hospital with them, to "protect" them from the processes of the hospital environment, but they are not yet interested in questioning the processes. Anne described these women as *"hard women to work with because they don't do any of the personal work of pregnancy and birth. Instead they expect you to be at their beck and call."* Elizabeth noted that it is most often women who come for labour support, rather than for homebirth who decide against midwifery care after their initial visit. She said *" I always feel like I am just walking on a fine line of not trying to break down their relationship with their physician and not compromising my own beliefs about giving her information about her choices in her childbirth experience."* The invitation to look more deeply at herself and at the world in which she lives may begin the cracking open that Madeleine experienced..

Elizabeth - Celebrating womanhood

> *As a midwife, I think it is really vital to have a connection to women. Part of that is a real celebration of womanhood. I don't remember being celebrated when I started my period and even when I had my babies. I wanted my husband to buy me flowers and he didn't. But my friend did. So, a woman just knows what feels important. I like celebrating womanhood.*

There are many joys to be discovered within a woman's space. These are celebrated together, with others who also value womanhood. In our culture, we have lost much of the sense of ritual, of ceremony, of celebration associated with women's lives. Some of the public celebrations are actually not celebrations of women at all. For example, the baptism ceremony originally was established to wash the child of the sins of the mother (Kramarae & Treichler, 1992). Often the celebrations of woman's space are quiet, private ones, a mutual sharing that something special has occurred. Perhaps these are not even noticed by others. Claire experienced a special celebration with her midwife after her birth. She said *"I was lying on the couch and my mom and mother-in-law were there. Pat brought my placenta over and showed us all the parts. It was a really neat female thing to do."* After Aiden's first birth, she was excited that she had no

lacerations at all. She said *"Melanie allowed me to boast and take all the glory even though she, of course, played a role in this."* She appreciated this opportunity to celebrate her own self and her abilities. With her next birth, she sensed an openness for a stronger partnership with Melanie. She described her way of participating: *"When I felt the burning sensation I said to Melanie, 'give me a hot cloth' and so I held a cloth on the top and she held one on the bottom. We worked in partnership to achieve an intact perineum."* Quiet, private celebrations have their own power, letting us recognize the opportunities available to us.

Some midwives have added a more formal celebration to their practices. The Blessingway is traditionally a First Nations menstrual or menarche ceremony (Grahn, 1993). Some midwives use this formal celebration prior to the birth to give the woman an opportunity to bring a group of her friends and family together to focus on the woman and the work that she is about to do. Hilary described the Blessingway as *"honouring the woman, giving the woman the strength to do what she needs to do."* Imagine sitting among a circle of supportive friends each focusing on you and this challenge that you are facing. Each bringing you a gift, perhaps a story, perhaps a candle, worry-beads, or music to help you through this challenge.

Some may criticize this notion of a company of women, perhaps worrying that this excludes the woman's male partner or other important male relations from the pregnancy and birth. By calling this women's work, we may challenge that relationship, causing rifts at a time when it is most important to strengthen the couple's commitment to one another. And yet, being *woman with woman* requires an attention to *this woman* in all her relations. Honouring the woman may increase the possibilities for her male partner. The woman who experiences the erotic, gains a power in this experience. She grows in her ability to know herself and follow her own cues, while continuing to be present to others. These others, of course, include the men with whom she holds important relations (Tomm, 1995).

Camille - Terry experienced something natural

> *I can remember the midwife suggesting that Terry hold me while they were putting in my epidural. I think for Terry, that was one of his first shifts because that was his first close physical contact with the pain that was in my body. I remember when I was pushing, Terry was watching and looking and seeing and even though this baby wasn't coming out, seeing what it looked like inside. It was something natural that he saw. It was important for both of us - the way the courage grew for us. When we were making the decision to have a cesarean, I remember Terry just crying and sobbing and that was the coming together that I really wanted for my birth. That he knew somehow that we weren't far apart anymore, that we were connected. It really helped me to make the decision about the cesarean. And it really helped him to understand the birth experience.*

Perhaps some are threatened by the notion of a company of women. We often hear that midwifery is too "political," too "feminist," even too "radical." We hear this in Heather's concerns about Ellen's anti-establishment stance on immunization, on the use of homeopathics, on the value of chiropractors. We are reminded of the "burning times" when women's power was met with fear (Brooke, 1995). We are reminded of other ways a company of women is devalued. Women's friendships may also challenge cultural norms of appropriate relations. We may hear these friendships labelled as frivolous, unimportant, gossip-generating, and if too close, dangerous (Raymond, 1986). While we hear midwives speaking clearly of the powerful experiences of women, we also hear them treading softly. They realize the dangers of making this too beautiful, too noticeable, a desired possession of others. This is how women lost control of the mysteries of womanhood (Griffin, 1978; Hall, 1980).

Women as Nurturers

Women are nurturers. They become expert on caring, supporting, "feeding," and watching others grow through the nature of their relations with others. Perri explained the need for nurturing in midwifery. *"Somehow women have a capacity for nurturing and that's what is needed for birth. To be able to nurture someone and to care for someone you have to be able to nurture yourself and I think that's what is difficult."* Whether nurturing others or nurturing

ourselves, this recognition of giving and receiving nurturance is a link that draws women together. For many women, the experience of giving so overpowers that of receiving that they are unaccustomed to being nurtured. Perhaps the *"midwife withdrawal"* described by Rachel is as much about leaving the nurturing as it is about saying goodbye to the midwife. When Jane said that she would never see the midwives again, perhaps she was also recognizing that she would never feel this kind of care again. This is *woman with woman* giving and receiving, sometimes like sisters, sometimes like friends, and sometimes like a mother and daughter. At times it reflects a desire to comfort and protect: Heather's back labour, Chantal's hospital transfer, and Camille's little candle. At times I feel fiercely protective of women. This mother-bear comes out mainly with women who are in hospital such as Beth who phoned me at 5 in the morning sobbing because the nurses would not help her with breastfeeding. While I drove to the hospital, I reminded myself to be diplomatic with the nurses, my anger would do nothing to help Beth. At times the nurturing reflects a desire to see growth, strength, and independence. Theresa found that her physician just told her not to worry, that he would take care of her. With her midwife, she found someone who not only made her feel safe, but who gave her wings to find her own strength.

We worry about connecting the nurturing role to women. So often in our society, the nurturers are not highly valued (Code, 1991; Sherwin, 1992). Women may be expected to nurture often, well, and frequently for little or no remuneration. Midwives sense a fine line between appropriate nurturing and creating dependencies. Anne noted that when she first began practising, it was easy to fall into a role where in her desire to provide good care, she created situations where the women became dependent upon her. Perhaps in viewing the nurturing role as a way of self-growth rather than only a giving and giving and giving, we can become comfortable with the claim that nurturing is central to women's experiences. Jason Elias and Katherine Ketcham (1995) suggest that by "awakening to the heart" (p.4) and attending to others, we gain a strength

within our self. This awakening is considered a feminine art, primarily enacted by women as life-givers and life-sustainers through their understanding that simple human contact is the most powerful way to heal.

Heather - A touch that heals

> *I think that my first thoughts of what it would be like to have another woman to help me came before my birth. Energy transfer is the key to midwifery. I suppose that they transfer enough energy to the mom so that she can do her job birthing the baby. And that energy transference between women is completely different than in the male of the species. The male may not even have that ability for whatever biological or evolutionary or creation reason. The male, I feel, doesn't have that easy transferring of energy where it actually goes through and perks you up. There's definitely a need for energy transfer if you are putting all that energy into pushing a baby out. And I think it's a female thing. You see it in lionesses, but you don't see it in the big old lion - he might gently whack, he's a whacker. The lioness is the one gently stroking and bathing the baby. The female elephant on her knees, pushing the baby out of the water hole if he gets stuck and the male is tooting his bullhorn. It's that connectedness, it's just a biology, it's very natural. I feel that the act of putting your hands on people can be really very healing, reassuring. And women are also needy that way - for the touch that heals.*

The nurturing touch of women is a touch that heals. It is sometimes a physical touch in a meeting of flesh. It is sometimes a verbal touch by just the right words. It is sometimes a spiritual touch in the meeting of two souls. Perhaps the power of this woman - to - woman touch is through the common ground of woman's experience. The energy that Heather described may be generated by recognizing and reflecting the power received from another woman, perhaps like the beacon in the lighthouse gains its brightness from reflectors. As one woman reaches out to another, her energy is magnified in recognizing the need, the experience of receiving the touch. She needs it too. As one woman receives the touch of another, her energy is magnified in recognizing the intent of the touch, the experience of giving. She often gives too.

Connection to All Women

This is the procession
of old leathery mothers,

the moon's last quarter
before the blank night,

mothers like worn gloves
wrinkled to the shapes of their lives,

passing the word from hand to hand,
mother to daughter,

a long thread of red blood, not yet broken. (Atwood, 1978, p.102).

Women have experienced pregnancy, labour, birth, nursing a baby since the beginning of human time. And, other women have helped them with these experiences. This link through history connects all women, a connection of quickening, pain, nursing, worries, fears, and celebration. Lea had an ancient feeling of connection during her birth. She felt as thought she had a guide for her birthing journey. A guide who was all women. Jean Shinoda Bolen (1994) spoke of her birthing experiences: "I had a mystical sense of oneness with all women through time. None of my accomplishments mattered or set me apart, my individuality meant nothing. In this experience, I was everywoman, anywoman, Woman. This was a profound revelation" (p.61).

When I am strongly focused on a birthing woman, I often have a sense of connection with the midwives, the birth helpers throughout time. It is easy to lose sight of the wallpaper in the bedroom, or the shiny cabinets in the kitchen and see only the woman. And I think, this is it, this is what every birth helper has seen through time. Nothing has changed. It is the woman and her power that will make this birth happen. I look at my hands and my heart and think that this is what every birth helper brought to the birth. Our knowledge and technologies evolve over time, but in the end, these are the things that count.

Woman's knowledge from the past was seldom recorded, except perhaps in everyday items such as pottery, weaving and quilting (Michaels, 1995). And yet this sense of being *everywoman* brings a knowledge that does not require writing. Perri tells women *"we are the ones giving birth and it's something that's been done since the beginning of time. You know how, and all women know how,*

and all women have done it and are still doing it." Women hold the knowledge of all time in our bodies. I remember hearing on the news that a gene from the first woman was isolated. Every woman carries that gene, we are all related, we all have something in common. Perhaps that gene awakens us to our history, to our knowledge, and to our womanhood. Perhaps history buried deep in our cells comes clear to us when we are thinking through our bodies. We have the knowledge within us, we just have to find it.

Chapter Eight

Completing the Circle

As I come to the end of this writing, I find myself asking *what did I learn?* As in all projects, I sense a need for a summary statement, a conclusion, a few simple phrases to say it all. And yet, as I read and re-read the preceding pages, I recognize that this is not possible. Perhaps not even desirable.

The intention of hermeneutic phenomenology is to develop an in-depth understanding of an experience as it occurs in our everyday world. In this study, I have attempted to understand what it is like to be *with woman* as a midwife and as a woman. It was through conversations and observations with women and midwives who have lived this experience that I entered into this process of understanding. Each woman had a story to tell: a story of her pregnancy, the birth of her baby, the birth of herself. These stories are heard throughout the study and are an important part of this understanding. And yet, a collection of stories alone is not enough to really understand this experience. Asking questions over and over throughout the research process: *what does this mean, what is this like, how else might I understand this* led me beyond the stories.

This understanding has been explored in depth through the identification of five themes: setting the tone for the relation, trust, having a birth experience, friendship, and awakening to our women-selves. These themes are not a way of dividing the experience of being *with woman* into particular categories which are clearly identifiable or mutually exclusive. Rather, each is a way of understanding the whole of the experience. The frequent overlapping and interweaving among the theme chapters is reassuring. If each theme discussion was totally disconnected from the others, I would question whether I had indeed come to more than a superficial understanding of this experience. It was these particular themes that I began to hear over and over as I read my transcripts, conversed with women and midwives, and reflected on my life as a midwife. It is likely that

there are many other themes that could be used to organize this writing or to come to other understandings of this experience.

Limitations

This research reflects my understanding of the experience of being *with woman* at this particular time. I recognize that it is not possible to capture the whole of understanding of any phenomenon (van Manen, 1990). There is always more to learn, to experience, and to consider. The phenomenon itself evolves, changes, and matures as other events and activities impinge upon it. Hans-Georg Gadamer (1992) suggests that it is the phenomena which change that attract our interest. Perhaps those which are more stagnant in their evolution become invisible to us. It is the changing nature of an experience that shakes our complacency, that causes us to question what the nature of this experience really is. Theresa recently invited me to her third homebirth. She told me that she had so much more to tell me about this experience of being *with woman*. This time, she had the birth she wanted, just Theresa, Drew and the midwives. As I watched her comfort with Irene and her confidence in her body, I realized that her story has changed.

My understanding of this experience has been influenced by the women and midwives who participated in this study. While these women and midwives were fairly representative of the current midwifery community, it is possible that in the future there will be a wider variety of cultures and social situations seen in the community. None of the women had a very negative experience with her midwife. However, some of the women did speak candidly about aspects of their experience that were not completely positive (e.g., Heather's discomfort around non-professional approaches, the death of Adele's daughter). I had met most of the women and all of the midwives prior to beginning this research. Perhaps our prior connections influenced what was disclosed in our conversations. Perhaps my understanding would be very different if every participant had been a stranger to me. Since I began this research, other midwives have joined the midwifery

community. Perhaps these newcomers will have additional insights into the understanding of this experience.

This study was completed during a period of transition in midwifery practice. The political and professional events during data collection and analysis had great potential to influence what women and midwives said to me, and how I then interpreted their words. As I review the transcripts, I can estimate the dates of the conversations by some of the comments about these events. I can recall periods of personal rage, for example following the midwifery registration assessment practical exam and following the Minister of Health's announcement that he would not fund midwifery services, when I had to put away this work for a few days. The inevitability of significant changes in midwifery practice over the next few years may mean that the nature of the midwifery relation will change in the future.

This is *my* understanding of the experience of being *with woman*. It is inevitable that my own experiences influence what I see and hear in others. I am a midwife, I live this experience every hour of every day. The very nature of this work, being on call, working erratic, sometimes very long hours demands a constant alertness to the responsibilities of being *with woman*. As I write, I am constantly aware of my work and as I work, I am constantly aware of my writing. I cannot separate these. And yet, my understanding has evolved through what I hear and see in others. The stories told by women and midwives frequently challenged my thinking, stimulated new ideas, and demanded that I venture into places I had not previously considered. Others share much of my understanding. Women and midwives who discussed this work, or read parts of the work expressed comfort or agreement with this understanding.

Application to practice

A question always asked of research done in practice disciplines is how the knowledge generated from the research may influence or be applied to practice. It is not the intention of hermeneutic phenomenology to develop theory or policies. There is not a single ideal way of being *with woman* that should be

used as a standard for practice or education. Hermeneutic phenomenology's orientation to the ineffable nature of life's experiences leads us to question the possibility of prescriptive theory (van Manen, 1990).

Some (e.g., Whitbeck, 1989) challenge the possibility of applying theory to practice. Theory is necessarily about *any woman* and *any midwife*. Theories are developed by constructing a system of statements that have as their purpose a way of "describing, explaining, predicting or prescribing responses, events, situations, conditions or relationships" (Meleis, 1991, p.12-13). Theories are not about *this woman* or *this midwife*, rather they are constructed around what we are most likely to see, most likely to expect given statistical probabilities. Sally Gadow (1993) suggests that theories are a form of general narrative. A general narrative assumes an authority that is not ascribed to any particular person, but to the theory itself. It is "as if the theory were speaking, as if its words were more true, more important, than the words a woman and her caregiver say with each other in their situation together" (Gadow, 1993, p.11). When the professional uses a theory to inform her practice, to prescribe which action she ought to take, she risks objectifying the woman, objectifying herself and objectifying their relation. Theory is about power, the power of the holders and keepers of the theory over those who are subject to the prescriptions of the theory. Carolyn Whitbeck (1989) suggests that the ultimate result of the use of authoritative knowledge to dominate or control is a lack of knowledge and understanding rather than a fuller understanding.

This criticism of the notion of applying theory to practice does not infer that knowledge development in the form of research is a futile activity. Knowledge in many forms shapes and is shaped by our everyday experiences. I would be paralysed in my practice if I needed to completely rediscover with every woman the knowledge and skills that may be appropriate to her care. This criticism does, however, point us to finding new ways of bringing our many knowledges into our practice so that the authority of the theory does not become the central focus of our way of being together. The knowledge that we use must be

connected to our everyday world, to our everyday experiences (Le Guin, 1989; Maeve, 1994). Susan Griffin (1992) suggests:

> We may have to relearn thinking. We have to learn to tolerate questions... we may have to cultivate patience. We may even have to learn to cultivate paradox, welcome contradiction or a troublesome question. We may have to learn to love knowledge for its own sake, not as a means to power... And this desire to know is perhaps finally a way of loving. It is intimately connected to an attitude which honors all that is living (p.291-292).

Some of the knowledge gained through this research challenges our traditions of professional relations. The blending of personal and professional relations is strongly disapproved in most healthcare (and other) professions. And yet, nearly every story I heard contains some degree of this blending. Perhaps this is reflective of overall experiences in healthcare. In movies, television, and novels, it is often the friendly physician, the nurse who is the next door neighbour who is the hero. We cheer when the cold professional sheds that armour and becomes more "human." In the movie *The Doctor* it was his friendship with a woman patient that gives him the insight of his own experience of being a cancer patient, and it was his best friend who he finally chose to be his surgeon. Perhaps we do know that technical and diagnostic skills are only part of what we need in healthcare. We also crave the touch that heals. We crave the human connection.

When I first thought about this project, I hoped to find a way to articulate this experience of being *with woman* in a short paragraph that could be appended to professional standards. This remains a challenge. The current law makers are only interested in objective, measurable competencies. And yet, this research has awakened a consciousness about being *with woman* within the midwifery community. Midwives and women who participated in the study reflected intensely on their experiences. When midwives come together to discuss our future as regulated professionals, the topic of relationships now often emerges. For example, one of the strongest criticisms of the registration exam process was that the experience of being in a committed relationship of *this*

midwife with *this woman* was never acknowledged. When we look to our colleagues in Ontario who have now lived in regulated practice for several years, the questions are often about relations. *How does it work to do shared care or have off call time? How can you turn away someone who desperately wants a homebirth? Has the client population shifted now that they do not need to pay? Has the midwife's practice changed now that she spends at least 50% of her time in hospital? How can you expect women to accept so many students?* These questions about Ontario midwifery are our questions as well. Midwifery in Alberta faces an uncertain future under regulation. There are many unanswered questions about how midwives will be integrated into the healthcare system, whether any funding for midwifery services will be found, and what role other professionals will take in influencing midwifery practice. Our understanding of being *with woman* will be challenged in many ways.

Seeking Legitimacy

The ultimate goal of professional regulation is to protect the public. Legislation and its ensuing regulation is meant to demonstrate to the public that the professionals who use a particular title have the knowledge and skills required for that work. In a healthcare system, the process of regulation of midwifery ought to be accompanied by credibility, status and a rightful place and voice within the system. In practical terms, these benefits ought to facilitate further development of the knowledge and practice base of midwifery, greater accessibility to midwifery for women, greater ease in accessing healthcare resources, and improvement of the working conditions of midwives.

Perhaps then, regulation will serve to strengthen being *with woman*. Perhaps if women need not worry whether they are selecting a safe or competent midwife, they will be able to move into other aspects of their experience much earlier. Claire, for example, spent many weeks contemplating the safeness issues before even making her phone call to Pat. The doubts, questions and concerns about choosing midwifery care occupied her first several visits. If she

could make assumptions that Pat was a safe practitioner, that the choice of midwifery care, and even of homebirth was a socially accepted safe choice, she may have started her midwifery care much earlier in pregnancy.

We have come to expect competence and safe practice of healthcare providers in our culture. Professional credentials bring us to a level of confidence which Otto Bollnow (1989,c) defines as a belief that "someone is capable of something" (p.38). Confidence is a one way activity. A woman can have confidence in the knowledge and skills of a midwife whom she has never met. Confidence can be an important first step in the further development of being *with woman*. A balance of the midwife's confidence in *any woman* with the woman's confidence in *any midwife* may bring an earlier sense of equality or partnership to the tone of the relationship. This confidence may open the possibility of midwifery to women who would otherwise not make the first phone call.

And yet, we must be cautious of our reliance on this notion of confidence to open the doors to in-depth, mutual relationships. After all, the assumption of confidence based on professional credentials is dominant within the healthcare system. When we hear of experiences where a care provider is described as an excellent technician but has a terrible bedside manner, we understand that competencies are indeed important to the care recipient, but not enough. Jema's friend was proceeding with her surgery, but did not have "total trust" in her surgeon. In these situations, confidence is all that is present. The mutual trust between *this woman* and *this surgeon* has not evolved. Claire described her process of working out doubts with Pat as an important step in building trust. She said *"I felt that we got to know each other, that we really listened to each other, to know our worries, our truths in as many facets as possible. I appreciated that she respected my perspective and so, I was able to respect hers. It was a very human, woman-to-woman way of relating. And I think that's why I felt that I could put my trust into that."* In Claire's situation, it was the lack

of confidence that brought her to trust her midwife. And, possibly, brought her midwife to trust her. Perhaps there are many other ways that Pat and Claire could have reached this trust. However, midwives must be mindful of the confidence that women bring into their first visit. This confidence may bring fewer questions or less fear. The midwife will need to build in other ways of opening doors to trust.

Stanley Gross (1984) questions the effectiveness of regulating and licensing healthcare professionals. While we are led to believe that regulations protect the public, the structures that support regulations such as professional associations, colleges, and limited-access education programmes, may make it difficult for the public to challenge the power of the professional group.

> Professionalism in medicine is nothing more than the institutionalization of a male, upper class monopoly. We must never confuse professionalism with expertise. Expertise is something to work for and to share; professionalism is... elitist and exclusive, sexist, racist and classist. (Ehrenreich & English, 1983, p.42).

Even when there is a mandate to include consumers in processes such as professional practice review, a minority consumer voice may do little to reduce the power of the professional group. There have been many examples where the consumer voice is hardly representative of the general public. Consumer representatives may be retired professionals, spouses of professionals or members of other healthcare professional groups. In my regional health authority midwifery working group, the appointed consumer has never and will never access midwifery care. When the focus is on regulation and competence rather than the actual caregiving and care receiving experience, the responsibility is shifted away from the individual selves involved in caregiving, *this woman, this midwife,* to objects: the public, the profession. It becomes easy to dismiss the

experience of an individual as "the whiner of the week"[1] when focusing only on the big picture.

Perhaps the formation of a regulatory body for midwifery enriches the possibilities of being *with woman.* Devising formal opportunities for midwives and women to dialogue about midwifery practice and professional issues away from the intensities of the particular working relationship of *this woman* and *this midwife* may reveal new insights for both women and midwives. This has enormous potential if the tone of *with woman* relations as described in this dissertation is maintained in this larger forum. Imagine the possibilities of reaching comfortable solutions to difficult, more global dilemmas such as setting an appropriate fee for midwifery services if the same attention, commitment and mutual respect that occurs between midwife and woman could also occur in a meeting of professionals and consumers.

A commitment to relational aspects of midwifery within the current context of professionalism will be a challenge for midwives and women. Existing professions and other stakeholders such as politicians and government bureaucrats are not accustomed to a relational model of organization. They may be suspicious of such a model. At a recent meeting of midwives, consumers, and government representatives at the Ministry of Health, we were told that the primary function of consumers in regulated midwifery practice is to be a "watchdog" for unacceptable practice. How can the woman assume a watchdog role at the same time as entering into a mutually respectful relationship? The watchdog is a guard, often a vicious snarling dog who will bite before discovering whether you are friend or foe, who is trained to be suspicious of every sound, every move. How do we open ourselves to trust an other when we are instructed to distrust? Always watching her every move. Always checking to be sure she is correct. The watchdog could never be a friend to those who are being

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[1]This phrase was used by Premier Ralph Klein throughout 1996 in response to individual reports of the negative impact of healthcare budget cuts and reform in the province of Alberta.

watched. This could cause the watchdog to be tricked, to let her guard down. This is not being *with woman*, this is an adversarial relation.

Challenge: Mandatory Consultation

The *Standards of Competency and Practice* (Alberta Labour, 1994) contains a detailed list of situations which require that the midwife consult with a physician. The purpose of this list is to further ensure that midwifery practice is safe. While the knowledge and skills in the competencies and the description of the scope of midwifery practice do clearly delineate acceptable, safe practice, the consultation list is an additional way to safeguard the public from midwives who may otherwise attempt to practice beyond their abilities. This list may be reassuring to the woman who would like to know explicitly what her midwife can and cannot do, and that she will be referred to and seen by a physician when her situation warrants this. Women and midwives both may benefit from mandatory consultation. On one hand, women who have been denied medical care or have received poor or inappropriate medical care because of the choice of midwifery and/or homebirth welcome these changes that accompany regulation. Bernie Pauly (1996) noted "no one listened to my midwife. [She] tried to tell them, but they didn't listen" (p.19). On the other hand, midwives who have had difficulty accessing appropriate care will be assured that care in accessible. Mandatory consultation ought to ensure that someone will listen to the midwife.

However, mandatory consultation challenges much of what has been highly valued within midwifery tradition. Rather than providing an alternative or challenge to the canons of medical care, midwives will now be required to be accountable to medicine. The decisions made in the relations formed between midwife and woman (and her family) will be subject to outside influence. Visible or invisible, physicians enter into the relationship and have a tremendous potential to influence the decision making process and the relation.

The consultation list contains unwritten messages which reinforce the traditional hierarchy within the healthcare system. The exclusive reference to

physicians for consultation implies that medicine is indeed at the top of the healthcare hierarchy. An additional message may imply that midwives are not adequately prepared to know when it is appropriate to consult physicians. The absence of similar lists for consultation with other care providers may imply that consultation with a lactation consultant, public health nurse, or homeopath, for example, is not critical to the provision of good care, or that the kind of knowledge required to make such consultations is not particularly complex.

How may these messages impact the trust in the midwife, both by the midwife herself and by women? Perhaps the woman will no longer be considered to be the central source of knowledge about her experience. Rather than inviting the woman to *tell about herself*, the focus may be on asking a set of fixed questions to discover whether the woman fits the picture of an appropriate midwife client. The onus is not on learning about *this woman*, the onus is on discovering whether she fits into any of the categories that place her at a statistically higher risk for pregnancy, birthing, and newborn complications. While this attention does not preclude learning about *this woman*, the midwife is not required to do so under regulation. Even when the woman and midwife are convinced that *this woman* is at no risk and *this midwife* is completely able to provide appropriate care, the consultation is still required.

Perhaps the midwife could attempt to bypass the formal consultation by explaining that the woman "knows" that she and her baby are fine, or that the midwife feels in her touch and in her heart that this woman will have a completely uncomplicated birth. But if this embodied knowledge is not valued by the consultant, this exercise is futile. Indeed, this may cause the midwife to lose credibility, making future consultations more difficult. Perhaps the midwife will begin to lose these particular skills of knowing with her body if their use seems to endanger her position within the system. She may not encourage the development of these skills in the woman, perhaps to "protect" the woman from the reaction to this kind of knowledge by others in the healthcare system. Recall

Laurel's experience with attempting to convince the physician that she believed her body was able to birth vaginally. He called her irrational. She said *"saying that is a terrible button to push with me. He was saying that I was irresponsible and endangering the life of my baby. He was intimating that he was the one who is sane and he is going to help someone insane."*

Perhaps midwives will find themselves relying more and more on the voices of medicine for directions as to how to act appropriately. Rose Weitz and Deborah Sullivan (1985) found that once licensed, midwives tended to use intuition less and to be more likely to interpret events through the medical model. The constant invisible presence of medicine may make it difficult to offer a choice of a wide variety of healing traditions to women. I recognize the intense angst currently experienced by women and families who are well connected to the healthcare system when making decisions such as having a homebirth, trying a homeopathic remedy, or using herbs. I have recently attended homebirths of two couples where both partners are healthcare providers. In both situations, they felt that they had to apologize to their colleagues for choosing homebirth. In fact, one couple chose not to inform their colleagues. The concern over the perceptions of powerful others touches us all.

A further challenge within the consultation process is the lack of a definition of "normal" with respect to pregnancy, birth, and the newborn in regulations and standards. This absence of definition may give the midwife the potential for greater flexibility in her decision making processes with *this woman*. However, the lack of a defined "normal" accompanied by physicians' exclusive privilege to diagnose[2] creates a legislative "loop-hole." The autonomy that

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[2]Throughout the *Midwifery Regulation* (1994) and *Standards of Competency and Practice* (1994), midwives are given the ability to assess and communicate the results of their assessment. Under current legislation in Alberta (and in other provinces), physicians are the only professionals who are able to "diagnose." While there may be a fine linguistic line between assessment and diagnosis, legislatively, diagnosis is considered to be a more authoritative act. Unless other professionals such as midwives are given authority to diagnose, there will always be the risk that a practitioner could be charged with practising medicine without a license if their decision-making

midwives sought could be limited by the ability of physicians to diagnose which women are indeed "normal" and therefore which women are suitable for midwifery care (Massey, 1993). Further complicating the lack of a definition of "normal" is the pervasive belief in medicine that pregnancy is not a "normal" condition.

In Alberta, the consultation lists were purposely written using very general terminology. This was done to create some flexibility in a midwife's practice dependent upon her relationship with consulting physicians and perhaps on her experience. There was also an attempt to facilitate expansion of the scope of midwifery practice in the future. For example, rather than using breech presentation as an indication for mandatory consultation, the term "abnormal presentation" was used. If at some time in the future, breech presentation is considered to be appropriate for midwifery care, there will be no need to open and change legislated standards. However, the general nature of these lists may in fact create local variations in how midwifery may be practised dependent upon interpretation by the physicians consulted. Using again the example of abnormal presentation, a midwife practising in a particular region of the province may be required to consult for all posterior presentations should the physician consider that to be "abnormal."

The consequences of choosing not to follow the advice of the consultant physician are not clearly outlined. While there is a sense that the woman, midwife and physician ought to collaborate in the decision making process, all described options in the course of care following the consultation with the physician are dependent upon the findings of the physician. By regulation, the physician's knowledge is the authoritative knowledge. While consultation generally implies asking for advice, there is an overall atmosphere of receiving orders in this consultation process. By regulation, the midwife should refuse care

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was seen to be based on diagnosis.

to any woman who decides against medical advice unless the woman is in labour, in which case the midwife may choose not to abandon her care. The option that the woman may not wish any physician consultation is not clearly outlined. The woman's "informed consent" is required prior to any transfer of care from midwife to physician, however there is no obligation to use any form of "consent" prior to consulting with a physician. In effect, the woman is completely left out of this process until it is underway. For many women, this may not be what they have come to expect of midwifery care. Laurel's obstetrician consulted with another physician about her situation without discussing with her his intention of doing so. This was unacceptable to her. She found a new obstetrician.

It is clear that failure to conform with the mandatory consultation regulations will jeopardize the midwife's registration status. Midwives who have worked outside of regulation may find themselves in conflicting situations where their previous ways of practising do not conform with consultation regulations. We can well imagine an experienced midwife questioning the need for consultation when she has been making decisions about these very situations without physician consultation for many years. This conflict may be further intensified when the woman is also accustomed to unregulated practice and asks the midwife to push the boundaries of her regulated practice. Midwives are accustomed to questioning practices - their own and those of other practitioners. Midwives encourage their clients to also participate in this questioning. A midwife's invitation to a woman to challenge "rules" such as mandatory consultation may compromise the trust between woman and midwife.

Perhaps the sense of mutual giving and receiving will influence women in their decisions about consultation and the recommendations made by consultants. A woman who feels a sense of caring for *this midwife* may recognize that a decision not to conform with a physician's advice may jeopardize her midwife's relation with that particular physician. That threat may

have numerous implications for the midwife's ongoing access to healthcare resources. If the particular issue at hand is seen by others as being particularly significant, the woman's decision may ultimately have implications for the midwife's registration status. As Laurel noted, women may take care of their midwives in order to take care of themselves. A woman may agree to follow the advice of the physician even when she does not feel comfortable with it. And, she may not tell the midwife that she is not comfortable so that she does not cause the midwife further concerns. Perhaps the situation is a little like the story *The gifts of the Magi* (Henry, 1972). Each - the midwife, the woman, and the physician - may continue making decisions, acting in what they consider to be the best interest of an other without sitting down together to really determine what is the most appropriate decision in this situation.

Challenge: Healthcare Reform

Midwifery regulation in Alberta has coincided with massive restructuring, downsizing and overall chaos within the healthcare system. Gaining a clear sense of midwifery practice under regulation has been extremely difficult. Rules and plans change daily. While many healthcare planners accept midwifery as a part of healthcare restructuring, their vision of midwifery may differ significantly from the model described in this dissertation. Often the vision of midwifery involves traditional institution-based practice where midwives are shifted through prenatal clinic, delivery room, and postpartum care. In this model, women receive their care from whichever midwife is available that particular day. The opportunities for being *with woman* as described in this study would be minimal.

The vision of midwifery of healthcare planners often involves restricting the practice of midwifery to particular geographical or social populations of women: populations in isolated rural areas, new immigrant women, or urban ghettos with low socio-economic conditions. In such a vision, women may be assigned to midwifery care rather than choosing midwifery care. In addition, a woman who might like to choose midwifery, may not be afforded that choice if

she does not meet the geographical or social criteria. While the majority of women who currently access midwifery care are educated, middle class women, midwives also provide care for women of other social populations. Indeed, one of the most compelling reasons that midwives have sought legislation is to make midwifery more accessible to all women who may be interested in this type of care. While midwives offer knowledge and skills that can be of great benefit to women assigned to them, a significant aspect of their caregiving style is based on the reality that the woman choses midwifery, making a commitment to this form of care and to *this midwife*. Midwives are concerned that the possibility of litigation will increase if women do not come to them by choice.

Part of restructuring of healthcare in Alberta is regionalised health care. Regional health authorities will decide whether midwifery will be an option in that particular region. The region will decide if it will pay for the services of midwives. As a powerful stakeholder in determining the midwife's ongoing access to healthcare resources and potentially as the midwife's paymaster, the regional health authority will become another, perhaps invisible, partner in the relationship between woman and midwife. The midwife may have to balance her responsibilities to the individual woman with her responsibilities to the regional health authority such as committee membership, fund raising or conference planning. The burdens of non-practice work are increased for midwives like myself who regularly provide care for women in five health regions. While women who have visits with their midwife interrupted by calls from other women come to be reassured that the midwife will give them the time when they need it, interruptions by calls about meetings, and other non-practice business may be a source of frustration and concern. *What if the midwife is tied up with one of these things when I go into labour? Will she be able to come? Will she be able to give me her attention?*

The question of whether there will be public funding for midwifery services is a complex one. On one hand, midwives recognize that the individual

requirement to pay for this service brings about a strong commitment from the woman (and her family). A young family struggling with financial responsibilities must really want midwifery services if they decide to assume this additional financial commitment. The midwife too, is conscious of this financial commitment and does not take her responsibilities lightly. Once registered, most midwives will need to double their service fee in order to cover the additional costs of regulated practice. They fear that this is a burden too large for many of their current clients. Of course, financial matters can complicate the development of any relationship - it is very important to clarify the fee at the outset of midwifery care. And yet, it is in this early stage of being *with woman* that both midwife and woman are most vulnerable in their decisions about how much to disclose about financial means and needs. The tiny resentments that may have begun at that first visit may evolve into mountains that interfere with trust, that interfere with entering into a commitment of working together as *this woman* and *this midwife*.

On the other hand, midwives recognize that many women do not access midwifery care because of financial constraints. If midwifery continues to be privately funded, the goal of universal access to midwifery will never be attained. Funding, however, may be accompanied by expectations for changes in the model of practice. In addition to geographic or social group restrictions, midwives may be expected to include non-midwives such as labour room nurses, on-call public health nurses or doulas[3] in aspects of their care if these personnel appear to represent cost savings to the healthcare system. Currently, midwives use other midwives as the second attendant (or back-up) at births. The woman generally knows the other midwife well by the time she is in labour. The

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[3]Originally, doulas were individuals who "mothered" the new mother, providing homemaking services, childcare and limited advice on mothering. More recently, a doula is an individual who provides labour support for a woman. Some doulas have completed a short programme which includes basic anatomy and physiology and a variety of supportive techniques. Many doulas wish to be midwives and see the doula experience as one way of entering into midwifery work. In some jurisdictions, doulas are seen as the midwife's assistant.

midwives know one another well and are accustomed to one another's working styles. This enables the midwife to continue her focus on the woman even while she is busy with the birth itself. Bringing in other professionals as the second attendant who may be relative strangers to the woman and to the midwife may disrupt the focus between woman and midwife, perhaps resulting in a situation where it appears as though the midwife is only attuned to the technical aspects of the birth and this second attendant is responsible for emotional support. The introduction of a second attendant with less qualifications (e.g., a doula) may build in a sense of hierarchy at the birth. The doula must wait for instructions from the midwife. How might the woman fit into this hierarchical arrangement? Will she be able to continue as a partner with the midwife?

An emphasis on cost cutting in the healthcare reform movement in Alberta has also created a mandate to demonstrate the effectiveness of any service. The randomized clinical trial has become the gold standard for evidence of effectiveness in most health disciplines. However, this research method does not always fit well with midwifery philosophy and practices. Midwives may find it difficult to randomly assign women to particular protocol groups when choice is a central aspect of practice. The dilemma for midwives is even stronger in situations where the midwife has developed an opinion about the effectiveness of a particular practice. Over the past few years, many midwives have received requests to recruit women into randomized clinical trials of the effectiveness of water (showers, bathing, hot tubs) in reducing labour pain. Most midwives already use water extensively in labour as a form of comfort. Midwives have not participated in these studies because they believed ethically they cannot claim that there is no difference in the use or non-use of water, nor can they withhold offering the use of water to a woman in the non-water group. And yet, if the use of water is only acceptable within this healthcare system if it is "proven" to be effective, midwives may feel obliged to participate fully in projects of this nature.

They may even rationalize this participation by thinking that women overall will benefit even if during the project, some women are "harmed."

Challenge: Formal Midwifery Education

In order to fully implement regulated midwifery in Alberta, a programme to educate individuals to meet the competencies required for midwifery registration will be needed. A formal programme may reassure women that their midwife does indeed have the knowledge and skills required to provide safe care. Some of Heather's concerns that midwives do not have a common knowledge or experiential base will be addressed through formal education. However, some women are concerned that students selected on academic merit and educated within a university environment will result in midwives who are very knowledgeable, perhaps technically skilled, but with little connection to the art and spirit of midwifery. The midwifery education programme in Ontario has incorporated many of the practice experiences traditionally used in midwifery apprenticeship. For example, students are required to work with one or two midwife mentors, providing continuity of care and being on call. However, even within a programme with good intentions, there is the risk that a focus on academic achievement, measured through an objective format may result in graduates who do very well in competencies that can be measured objectively, but may not develop skills in the relational aspects of midwifery.

Women and midwives may also feel an obligation to provide experiences to students, introducing yet another person and potentially unspoken expectations into the relationship between midwife and woman. In Ontario, the woman's willingness to involve 2 or more students in various aspects of her care is used as one of several criteria in gaining access to midwifery care.[4] While it may be possible for woman and midwife to include several others in the *we*

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[4]With fully funded midwifery services, the demand for midwifery far outweighs the supply of midwives in Ontario. Women who wait even until the second month of their pregnancy are unlikely to find an available midwife.

involved in being *with woman*, some may find it difficult to move their relationship beyond assumed confidence and a superficial knowledge of one another when there are so many interconnected relations to work on. Aiden described her experience: *"I felt it was very important to have a primary caregiver who I could count on and develop a relationship with. I don't think I could have established two good relationships with two midwives. It would take a lot of energy."*

Meeting the Challenges

While midwifery regulation carries a potential to strengthen the experience of being *with woman*, there are a number of challenges that may jeopardize the nature of the midwifery relation. There are many ways in which midwives could find themselves in adversarial relations with the women for whom they are providing care. The legislation itself that enables the full scope of midwifery practice has built in a variety of visible and invisible partners in the midwifery relation. The company of women has interlopers who may or may not value the knowledge, the power, the experiences discovered within this particular relation.

Once part of the healthcare system, midwives will be under enormous pressures to conform to the marketplace and business models that are dominant in current healthcare politics. If midwives and women are to continue to recognize the face of midwifery, even if in a more "mature" form, it will be vital to learn ways of communicating the relationship models which have evolved through the emergence of "modern" midwifery. This company of women has strength. It is amazing that such a small group of women has accomplished this much so far. We need to take our knowledge of this strength into the healthcare arena. Through the experience of being *with woman*, we have learned that we can birth, we can provide safe and appropriate care without the paternalistic protection of other powerful professionals. We should choose our relations of trust wisely, not out of fear or intimidation. There may be many occasions along this journey of transition where midwives and women need to reach out to others to assist us. If we remind ourselves that this is another phase in our birth of

ourselves as women, we may hold the sense of *with woman* rather than abandoning our ideals because others do not understand what we say.

A Beginning

Usually the last section is the conclusion. And yet as I reach this point, I find myself completing a circle. I am at a beginning again. Some refer to a hermeneutic circle (e.g., Gadamer, 1992) where each level of understanding opens new possibilities to us, causing us to ask new questions, inviting us to dig deeper, wider, farther. In this past week I have found myself questioning again my understanding of women's and midwives' experiences.

I attended a birth where the woman decided in the transition stage of her labour to stay home. Was there something unspoken between us that led us to postpone the decision of moving to hospital until it was too late, knowing that her partner had strong feelings against homebirth?

I listened to a midwife struggle over her relationship with one of her midwife partners, a relationship that is currently strained because the partner does not like one of the midwife's clients. How do we find a balance in our relations with the women with whom we work - our partners and our clients?

I listened to a very young woman who had a homebirth at age 16 carefully explain the merits of midwifery and homebirth to a couple in their late 30's. Where did she find that wisdom?

I have spoken to many past clients this week about a letter writing campaign for midwifery funding. Many took the time to catch me up with their lives and to ask me about mine. Many wished that they had time to come for a real visit, perhaps stay for lunch. One woman and her six month old daughter came for lunch at our clinic this week and stayed the whole afternoon. She said it was so pleasant to "hang out" with the midwives. Do we do too much or too little to encourage this company of women or this midwifery community? How do we find ways of explaining the value of being *with woman* in ways that extend

past the childbearing experience, particularly in a culture that is sometimes suspicious of women's relationships and fearful of women's power?

I have listened to midwives, consumers and healthcare planners discuss alternative models of midwifery care. Midwives, women and families speak with excitement of ideas of how the community based practice model could be expanded to be more accessible, to interface with other care providers, and to offer well woman health services. Healthcare planners speak of how midwives will have to give up community based practice and come into the institutions - hospitals, health centres, or clinics. How do we find a common ground in this quest to integrate midwives into the healthcare community? Can midwives provide care to a broader population base within the community based practice model? Can the midwifery relation be maintained in alternative models? Can midwives articulate the value of being *with woman* in a way that other healthcare providers will understand, respect and perhaps also integrate into their practices?

I am reminded of Hildegard of Bingen's advice to be "green" (*viriditas*). In her view, being "green" involves being emotionally committed, creative and mindful of our connections: body, mind, soul, earth, and others. In being "green," we are called to a stance of innocence, seeing our world always with fresh eyes, never assuming a position of expert, of final knowledge or truth (Bolen, 1994). It is this innocence that allows us to hear the unwritten words from our past, to be open to seemingly opposing truths, and to trust ourselves as we move into the unknowns of the future. While we can be comfortable with our understanding of the experience of being *with woman* for this moment, we are constantly mindful of the word, the action, the thought that captures our attention and leads us to reflect and to look again at this experience.

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Appendix A

Interview Schedule

Women

W001	May 12, 1995
W002	May 15, 1995
W003	May 27, 1995
W004	June 12, 1995
W005	June 13, 1995
W006	June 21, 1995
W007	July 14, 1995
W008	July 16, 1995
W009	September 2, 1995
W010	September 14, 1995
W011	September 16, 1995
W012	October 12, 1995

Midwives

MW001	May 18, 1995
MW002	June 17, 1995
MW003	July 7, 1995
MW004	October 3, 1995
MW005	October 4, 1995
MW006	October 28, 1995
MW007	February 3, 1996
MW008	March 15, 1996
MW009	April 2, 1996
MW010	May 14, 1996

Appendix B

Sample Recruitment Letters and Advertising

Letter to midwives asking for narratives:

I am a graduate student at the University of Alberta and a practising midwife in Edmonton. I am doing a study about the relations that develop between women and their midwives. I would like to learn more about how women and midwives experience these relations. I want to understand this through the eyes of women and their midwives.

I am asking you, as a midwife, to help me with my study by sending me a written or tape recorded account or "story" of a situation (or situations) that you have experienced in your practice that you believe illustrates what it is like for you to develop relations with the women you meet in your practice.

You do not need to put your name or any other identifying information on your story. I may use parts of your story in the written report of my research or in presentations about my research. If you have identified yourself to me, I will not use your name in any reports, publications or presentations. I will use a code name to refer to you. If you wish, you may include a code name of your choice with your story. If there are parts of your story that you do not want me to put into writing or read at a presentation, I will not. You just need to include these instructions with your story.

Another way that I am collecting information for my study is by interviewing midwives. If you are interested in participating in an interview, please complete one copy of the consent form included and mail it to me. You may mail it separately from you story. I will telephone you to arrange an interview time with you. I you prefer, you may telephone me to ask about an interview.

Thank you for taking time from your busy life as a midwife to help me with this study.

Susan James
Faculty of Nursing
University of Alberta
ANR 222, 8220-114 Street
Edmonton, AB T6G 2J3
1-403-2988
1-403-0673 (fax)
sjames@ua-nursing.ualberta.ca (e-mail)

Letter to midwives regarding interviews:

***Project Title*: With Woman: The Nature of the Midwifery Relation**

Researcher: **Susan James**
PhD Candidate, Faculty of Nursing
University of Alberta
492-2988

Advisor: **Dr. Vangie Bergum**
Faculty of Nursing
University of Alberta
492-6676

Purpose: This is a study to describe and interpret relations between women and their midwives. I am interested in learning about these relations through the eyes of women and their midwives.

Procedure: I will interview you at a time and place of your convenience. In the interview, I will ask you to tell me about your experiences of your relations with women as a midwife. The interview will likely last between one and two hours. I may ask you if I may interview you again if I find I have additional questions as I go through this research project. I would like to tape record the interview. I will turn off the tape recorder whenever you wish that I do not record a part of your discussion. I will provide you with a copy of the typed transcript of your interview if you wish. You may ask me to leave parts of your interview out of the research. You may want to add more information to the interview if you think that it will help me understand your experience better.

Your Participation: Results from this study may help midwives to gain a stronger understanding of the relationships that they develop with the women who receive their care. This may help to improve the care that midwives give to women.

You do not have to be in this study if you do not wish to be. If you decide to be in the study, you may drop out at any time. You just need to tell me or my advisor (Dr. Vangie Bergum). You do not have to answer any questions or discuss any subject in the interview if you do not want to.

Your name will not appear in this study. I will use a code name when I refer to you in the report of the study. If you wish, you may select your code name. During the research process, the only people besides myself who will have access to the tapes or typed interview will be members of my research committee and a transcriber who may type the interview. I will keep all the tapes and typed interviews and any other written information about you in a locked cabinet. I will keep the tapes for at least seven years after I complete the study. If you agree, I or another researcher may use the typed interviews for another study in the future. I or another researcher will seek approval from the appropriate ethical review committee before beginning another study.

I may publish or present the information and findings of this study. I will not use your name or any material that may identify you in publications or presentations. If you have questions or concerns about this study at any time, you can call me or my advisor at the numbers above.

Appendix C

Sample Consent Form

***Project Title*: With Woman: The Nature of the Midwifery Relation**

Researcher: **Susan James**
PhD Candidate, Faculty of Nursing
University of Alberta
492-2988

Advisor: **Dr. Vangie Bergum**
Faculty of Nursing
University of Alberta
492-6676

Purpose: This is a study to describe and interpret relations between women and their midwives. I am interested in learning about these relations through the eyes of women and their midwives.

Procedure: There are several ways that I am gathering information for this study. Each of these is described below. You may decide to participate in any or all of the procedures.

1. Interviews: I will interview you at a time and place of your convenience. In the interview, I will ask you to tell me about your experiences of your relationship with your midwife (midwives). The interview will likely last between one and two hours. I may ask you if I may interview you again if I find I have additional questions as I go through this research project. I would like to tape record the interview. I will turn off the tape recorder whenever you wish that I do not record a part of your discussion. I will provide you with a copy of the typed transcript of your interview if you wish. You may ask me to leave parts of your interview out of the research. You may want to add more information to the interview if you think that it will help me understand your experience better.

2. Observations: I will observe you and your midwife at (a) place(s) and situation(s) of your choosing only if all individuals involved with the observation situation agree with my presence. This may occur in a prenatal class, prenatal or postnatal clinic appointment, homevisit, or birth. I am not watching for particular techniques or knowledge. I am interested in learning more about how a midwife works with women. However, if I do see something that concerns me, I will discuss it with you and your midwife. The level of my involvement in the situation can vary depending on your preference, your midwife's preference, and the preference of the others participating in the situation. For example, I can sit quietly in a corner, or I may be involved in some way with the activities of the situation. If at any time, you or anyone else participating in the situation feels uncomfortable with being observed, I will leave. You just have to ask me to. I will not take notes during the time of the observation. I will make notes about my observations as soon as possible following the situation. If you wish to discuss the observation with me, I will do so at a time and place that is convenient to you.

3. Group Discussion: You will participate in a group discussion with other women who have received care from a midwife. The discussion will be focused on women's experiences with their relationships with their midwife or midwives. There will be eight to twelve women in the group. The discussion will last one to two hours. The place and time will be arranged taking into consideration the availability of all in the group. I will be present as part of the group. I would like to tape record the discussion. I will turn off the tape recorder at any time one or more group members wish that something is not recorded. I will send you a copy of the transcript of the discussion if you wish.

Your Participation: Results from this study may help midwives to gain a stronger understanding of the relationships that they develop with the women who receive their care. This may help to improve the care that midwives give to women.

You do not have to be in this study if you do not wish to be. If you decide to be in the study, you may drop out at any time. You just need to tell me or my advisor (Dr. Vangie Bergum). You do not have to answer any questions or discuss any subject in the interview if you do not want to. Taking part in this study or dropping out will not affect the care you receive from your midwife.

Your name will not appear in this study. I will use a code name when I refer to you in the report of the study. If you wish, you may select your code name. During the research process, the only people besides myself who will have access to the tapes or typed interview will be members of my research committee and a transcriber who may type the interview. I will keep all the tapes and typed interviews and any other written information about you in a locked cabinet. I will keep the tapes for at least seven years after I complete the study. If you agree, I or another researcher may use the typed interviews for another study in the future. I or another researcher will seek approval from the appropriate ethical review committee before beginning another study.

I may publish or present the information and findings of this study. I will not use your name or any material that may identify you in publications or presentations. If you have questions or concerns about this study at any time, you can call me or my advisor at the numbers above.

Your Consent: I acknowledge that the above research procedures have been described. Any questions have been answered to my satisfaction. In addition, I know that I may contact Susan James or Dr. Vangie Bergum if I have further questions either now or in the future. I have been informed that I do not have to be in this study. I understand that there are no harms or direct benefits of joining the study. I have been assured that the records relating to this study will be kept confidential. I understand that I am free to withdraw from the study at any time by telling Susan James or Dr. Vangie Bergum. I further understand that if I do not participate in the study or withdraw at any time, my midwifery care will not be affected. I have been given a copy of this form to keep.

I consent to being interviewed.	YES	NO
I consent to being observed.	YES	NO
I consent to participating in the group discussion.	YES	NO

I agree that Susan James may keep typed interviews, typed group discussion notes and/or observation notes for use in the future. YES NO

_____ _____

signature of participant date

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If you wish to receive a summary of the study when it is finished, please complete the next section:

Name:_____

Address:_____